

**AMENDMENT TO H.R. 3046**  
**AS REPORTED BY THE SUBCOMMITTEE ON**  
**HEALTH**

Strike all after the enacting clause and insert the following:

1    **SECTION 1. SHORT TITLE; AMENDMENTS TO SOCIAL SE-**  
2    **CURITY ACT; TABLE OF CONTENTS.**

3           (a) SHORT TITLE.—This Act may be cited as the “Medi-  
4    care Regulatory, Appeals, Contracting, and Education Reform  
5    Act of 2001”.

6           (b) AMENDMENTS TO SOCIAL SECURITY ACT.—Except as  
7    otherwise specifically provided, whenever in this Act an amend-  
8    ment is expressed in terms of an amendment to or repeal of  
9    a section or other provision, the reference shall be considered  
10   to be made to that section or other provision of the Social Se-  
11   curity Act.

12          (c) BIPA; SECRETARY.—In this Act:

13           (1) BPIA.—The term “BIPA” means the Medicare,  
14    Medicaid, and SCHIP Benefits Improvement and Protec-  
15    tion Act of 2000, as enacted into law by section 1(a)(6) of  
16    Public Law 106–554.

17           (2) SECRETARY.—The term “Secretary” means the  
18    Secretary of Health and Human Services.

19          (d) TABLE OF CONTENTS.—The table of contents of this  
20    Act is as follows:

Sec. 1. Short title; amendments to Social Security Act; table of contents.  
Sec. 2. Findings.  
Sec. 3. Construction.

**TITLE I—REGULATORY REFORM**

Sec. 101. Issuance of regulations.  
Sec. 102. Compliance with changes in regulations and policies.  
Sec. 103. Report on regulatory burdens.  
Sec. 104. Report on the sustainable growth rate and regulatory costs.

**TITLE II—APPEALS PROCESS REFORM**

Sec. 201. Transfer of responsibility for medicare appeals.  
Sec. 202. Expedited access to judicial review.

## 2

- Sec. 203. Expedited review of certain provider agreement determinations.
- Sec. 204. Revisions to medicare appeals process.
- Sec. 205. Hearing rights related to decisions by the Secretary to deny or not renew a medicare enrollment agreement.
- Sec. 206. Appeals by providers when there is no other party available.
- Sec. 207. Process for exceptions to national coverage determinations under special medical circumstances.
- Sec. 208. BIPA-related technical amendments and corrections.

## TITLE III—CONTRACTING REFORM

- Sec. 301. Increased flexibility in medicare administration.
- Sec. 302. Requirements for information security.

## TITLE IV—EDUCATION AND OUTREACH IMPROVEMENTS

- Sec. 401. Provider education and technical assistance.
- Sec. 402. Access to and prompt responses from medicare administrative contractors.
- Sec. 403. Reliance on guidance.
- Sec. 404. Facilitation of consistent information to providers.
- Sec. 405. Policy development regarding evaluation and management (E & M) documentation guidelines.
- Sec. 406. Beneficiary outreach demonstration program.
- Sec. 407. Provider enrollment applications.

## TITLE V—REVIEW, RECOVERY, AND ENFORCEMENT REFORM

- Sec. 501. Prepayment review.
- Sec. 502. Recovery of overpayments.
- Sec. 503. Process for correction of minor errors and omissions on claims without pursuing appeals process.
- Sec. 504. Authority to waive a program exclusion.
- Sec. 505. Clarification of prudent layperson test for emergency services under the medicare fee-for-service program.

## TITLE VI—COVERAGE AND CODING IMPROVEMENTS

- Sec. 601. Methods for determining payment basis for new lab test.

1    **SEC. 2. FINDINGS.**

2           Congress finds the following:

3           (1) The overwhelming majority of providers of serv-  
 4           ices, physicians, practitioners, facilities, and suppliers in  
 5           the United States are law-abiding persons who provide im-  
 6           portant health care services to patients each day.

7           (2) The Secretary of Health and Human Services  
 8           should work to streamline paperwork requirements under  
 9           the medicare program and communicate clearer instruc-  
 10          tions to providers of services, physicians, practitioners, fa-  
 11          cilities, and suppliers so that they may spend more time  
 12          caring for patients.

1     **SEC. 3. CONSTRUCTION.**

2           (a) NO EFFECT ON LEGAL AUTHORITY.—Nothing in this  
3     Act shall be construed to compromise or affect existing legal  
4     authority for addressing fraud or abuse, whether it be criminal  
5     prosecution, civil enforcement, or administrative remedies, in-  
6     cluding under sections 3729 through 3733 of title 31, United  
7     States Code (known as the False Claims Act).

8           (b) NO EFFECT ON MEDICARE WASTE, FRAUD, AND  
9     ABUSE EFFORTS.—Nothing in this Act shall be construed to  
10    prevent or impede the Department of Health and Human Serv-  
11    ices in any way from its ongoing efforts to eliminate waste,  
12    fraud, and abuse in the medicare program.

13          (c) CLARIFICATION RELATED TO MEDICARE TRUST  
14    FUNDS.—The consolidation of medicare administrative con-  
15    tracting set forth in this Act does not constitute (or reflect any  
16    position on the issue of) consolidation of the Federal Hospital  
17    Insurance Trust Fund and the Federal Supplementary Medical  
18    Insurance Trust Fund.

19     **TITLE I—REGULATORY REFORM**

20     **SEC. 101. ISSUANCE OF REGULATIONS.**

21          (a) CONSOLIDATION OF PROMULGATION TO ONCE A  
22    MONTH.—

23           (1) IN GENERAL.—Section 1871 (42 U.S.C. 1395hh)  
24    is amended by adding at the end the following new sub-  
25    section:

26           “(d)(1) Subject to paragraph (2), the Secretary shall issue  
27    proposed or final (including interim final) regulations to carry  
28    out this title only on one business day of every month.

29           “(2) The Secretary may issue a proposed or final regula-  
30    tion described in paragraph (1) on any other day than the day  
31    described in paragraph (1) if the Secretary—

32           “(A) finds that issuance of such regulation on another  
33    day is necessary to comply with requirements under law; or

34           “(B) finds that with respect to that regulation the lim-  
35    itation of issuance on the date described in paragraph (1)  
36    is contrary to the public interest.

1 If the Secretary makes a finding under this paragraph, the  
2 Secretary shall include such finding, and brief statement of the  
3 reasons for such finding, in the issuance of such regulation.”.

4 (2) REPORT ON PUBLICATION OF REGULATIONS ON A  
5 QUARTERLY BASIS.—Not later than 3 years after the date  
6 of the enactment of this Act, the Comptroller General of  
7 the United States shall submit to Congress a report on the  
8 feasibility of requiring that regulations described in section  
9 1871(d) of the Social Security Act be promulgated on a  
10 quarterly basis rather than on a monthly basis.

11 (3) EFFECTIVE DATE.—The amendment made by  
12 paragraph (1) shall apply to regulations promulgated on or  
13 after the date that is 30 days after the date of the enact-  
14 ment of this Act.

15 (b) REGULAR TIMELINE FOR PUBLICATION OF FINAL  
16 REGULATIONS.—

17 (1) IN GENERAL.—Section 1871(a) (42 U.S.C.  
18 1395hh(a)) is amended by adding at the end the following  
19 new paragraph:

20 “(3)(A) The Secretary, in consultation with the Director  
21 of the Office of Management and Budget, shall establish a reg-  
22 ular timeline for the publication of final regulations based on  
23 the previous publication of a proposed regulation or an interim  
24 final regulation.

25 “(B) With respect to publication of final regulations based  
26 on the previous publication of a proposed regulation, such  
27 timeline may vary among different regulations based on dif-  
28 ferences in the complexity of the regulation, the number and  
29 scope of comments received, and other relevant factors.

30 “(C)(i) With respect to the publication of final regulations  
31 based on the previous publication of an interim final  
32 regulation—

33 “(I) subject to clause (ii), the Secretary shall publish  
34 the final regulation within the 12-month period that begins  
35 on the date of publication of the interim final regulation;

36 “(II) if a final regulation is not published by the dead-  
37 line established under this subparagraph, the interim final

1 regulation shall not continue in effect unless the Secretary  
2 publishes a notice described in clause (ii) by such deadline;  
3 and

4 “(III) the final regulation shall include responses to  
5 comments submitted in response to the interim final regu-  
6 lation.

7 “(ii) If the Secretary determines before the deadline other-  
8 wise established in this subparagraph that there is good cause,  
9 specified in a notice published before such deadline, for delay-  
10 ing the deadline otherwise applicable under this subparagraph,  
11 the deadline otherwise established under this subparagraph  
12 shall be extended for such period as the Secretary specifies in  
13 such notice.”.

14 (2) EFFECTIVE DATE.—The amendment made by  
15 paragraph (1) shall take effect on the date of the enact-  
16 ment of this Act. The Secretary shall provide for an appro-  
17 priate transition to take into account the backlog of pre-  
18 viously published interim final regulations.

19 (c) LIMITATIONS ON NEW MATTER IN FINAL REGULA-  
20 TIONS.—

21 (1) IN GENERAL.—Section 1871(a) (42 U.S.C.  
22 1395hh(a)), as amended by subsection (b), is further  
23 amended by adding at the end the following new para-  
24 graph:

25 “(4) Insofar as a final regulation (other than an in-  
26 terim final regulation) includes a provision that is not a  
27 logical outgrowth of the relevant notice of proposed rule-  
28 making relating to such regulation, that provision shall be  
29 treated as a proposed regulation and shall not take effect  
30 until there is the further opportunity for public comment  
31 and a publication of the provision again as a final regula-  
32 tion.”.

33 (2) EFFECTIVE DATE.—The amendment made by  
34 paragraph (1) shall apply to final regulations published on  
35 or after the date of the enactment of this Act.

1   **SEC. 102. COMPLIANCE WITH CHANGES IN REGULA-**  
2   **TIONS AND POLICIES.**

3       (a) NO RETROACTIVE APPLICATION OF SUBSTANTIVE  
4   CHANGES.—

5           (1) IN GENERAL.—Section 1871 (42 U.S.C. 1395hh),  
6       as amended by section 101(a), is amended by adding at the  
7       end the following new subsection:

8           “(e)(1)(A) A substantive change in regulations, manual in-  
9       structions, interpretative rules, statements of policy, or guide-  
10      lines of general applicability under this title shall not be applied  
11      (by extrapolation or otherwise) retroactively to items and serv-  
12      ices furnished before the effective date of the change, unless  
13      the Secretary determines that—

14           “(i) such retroactive application is necessary to comply  
15      with statutory requirements; or

16           “(ii) failure to apply the change retroactively would be  
17      contrary to the public interest.”.

18           (2) EFFECTIVE DATE.—The amendment made by  
19      paragraph (1) shall apply to substantive changes issued on  
20      or after the date of the enactment of this Act.

21       (b) TIMELINE FOR COMPLIANCE WITH SUBSTANTIVE  
22   CHANGES AFTER NOTICE.—

23           (1) IN GENERAL.—Section 1871(e)(1), as added by  
24      subsection (a), is further amended by adding at the end the  
25      following:

26           “(B) A compliance action may be made against a provider  
27      of services, physician, practitioner, facility, or supplier with re-  
28      spect to noncompliance with such a substantive change only for  
29      items and services furnished on or after the effective date of  
30      the change.

31           “(C)(i) Except as provided in clause (ii), a substantive  
32      change may not take effect before the end of the 30-day period  
33      that begins on the date that the Secretary has issued or pub-  
34      lished, as the case may be, the substantive change.

35           “(ii) The Secretary may provide for a substantive change  
36      to take effect on a date that precedes the end of the 30-day  
37      period under clause (i) if the Secretary finds that waiver of

1 such 30-day period is necessary to comply with statutory re-  
2 quirements or that the application of such 30-day period is con-  
3 trary to the public interest. If the Secretary provides for an  
4 earlier effective date pursuant to this clause, the Secretary  
5 shall include in the issuance or publication of the substantive  
6 change a finding described in the first sentence, and a brief  
7 statement of the reasons for such finding.”.

8 (2) EFFECTIVE DATE.—The amendment made by  
9 paragraph (1) shall apply to compliance actions undertaken  
10 on or after the date of the enactment of this Act.

11 **SEC. 103. REPORT ON REGULATORY BURDENS.**

12 Section 1871 (42 U.S.C. 1395hh), as amended by sections  
13 101(a) and 102, is amended by adding at the end the following  
14 new subsection:

15 “(f)(1) Not later than 2 years after the date of the enact-  
16 ment of this subsection, and every 2 years thereafter, the Sec-  
17 retary shall submit to Congress a report with respect to the ad-  
18 ministration of this title and areas of inconsistency or conflict  
19 among the various provisions under law and regulation.

20 “(2) In preparing a report under paragraph (1), the Sec-  
21 retary shall collect—

22 “(A) information from beneficiaries, providers of serv-  
23 ices, physicians, practitioners, facilities, and suppliers, and  
24 from the individual under section 404 of the Medicare Reg-  
25 ulatory, Appeals, Contracting, and Education Reform Act  
26 of 2001 with respect to such areas of inconsistency and  
27 conflict; and

28 “(B) information from medicare contractors that  
29 tracks the nature of written and telephone inquiries.

30 “(3) A report under paragraph (1) shall include a descrip-  
31 tion of efforts by the Secretary to reduce such inconsistency or  
32 conflicts, and recommendations for legislation or administrative  
33 action that the Secretary determines appropriate to further re-  
34 duce such inconsistency or conflicts.”.

1   **SEC. 104. REPORT ON THE SUSTAINABLE GROWTH RATE**  
2       **AND REGULATORY COSTS.**

3       Not later than 18 months after the date of the enactment  
4   of this Act, the Comptroller General of the United States shall  
5   submit to Congress a report on the accuracy of the sustainable  
6   growth rate (under section 1848(f) of the Social Security Act,  
7   42 U.S.C. 1395w-4(f)) for 2002 and succeeding years in ac-  
8   counting for regulatory costs imposed on physicians.

9       **TITLE II—APPEALS PROCESS**  
10       **REFORM**

11   **SEC. 201. TRANSFER OF RESPONSIBILITY FOR MEDI-**  
12       **CARE APPEALS.**

13       (a) TRANSITION PLAN.—

14       (1) IN GENERAL.—Not later than October 1, 2002,  
15   the Commissioner of Social Security and the Secretary  
16   shall develop and transmit to Congress and the Comptroller  
17   General of the United States a plan under which the func-  
18   tions of administrative law judges responsible for hearing  
19   cases under title XVIII of the Social Security Act (and re-  
20   lated provisions in title XI of such Act) are transferred  
21   from the responsibility of the Commissioner and the Social  
22   Security Administration to the Secretary and the Depart-  
23   ment of Health and Human Services.

24       (2) CONTENTS.—The plan shall include information  
25   on the following:

26       (A) WORKLOAD.—The number of such administra-  
27   tive law judges and support staff required now and in  
28   the future to hear and decide such cases in a timely  
29   manner, taking into account the current and antici-  
30   pated claims volume, appeals, number of beneficiaries,  
31   and statutory changes.

32       (B) COST PROJECTIONS.—Funding levels required  
33   for fiscal year 2004 and subsequent fiscal years under  
34   this subsection to hear such cases in a timely manner.

35       (C) TRANSITION TIMETABLE.—A timetable for the  
36   transition.

1 (D) REGULATIONS.—The establishment of specific  
2 regulations to govern the appeals process.

3 (E) CASE TRACKING.—The development of a uni-  
4 fied case tracking system that will facilitate the mainte-  
5 nance and transfer of case specific data across both the  
6 fee-for-service and managed care components of the  
7 medicare program.

8 (F) FEASIBILITY OF PRECEDENTIAL AUTHOR-  
9 ITY.—The feasibility of developing a process to give de-  
10 cisions of the Departmental Appeals Board in the De-  
11 partment of Health and Human Services addressing  
12 broad legal issues binding, precedential authority.

13 (G) ACCESS TO ADMINISTRATIVE LAW JUDGES.—  
14 The feasibility of filing appeals with administrative law  
15 judges electronically, and the feasibility of conducting  
16 hearings using tele- or video-conference technologies.

17 (3) ADDITIONAL INFORMATION.—The plan may also  
18 include recommendations for further Congressional action,  
19 including modifications to the requirements and deadlines  
20 established under section 1869 of the Social Security Act  
21 (as amended by sections 521 and 522 of BIPA, 114 Stat.  
22 2763A–534).

23 (4) GAO EVALUATION.—The Comptroller General of  
24 the United States shall evaluate the plan and, not later  
25 than April 1, 2003, shall submit to Congress a report on  
26 such evaluation.

27 (b) TRANSFER OF ADJUDICATION AUTHORITY.—

28 (1) IN GENERAL.—Not earlier than July 1, 2003, and  
29 not later than October 1, 2003, the Commissioner of Social  
30 Security and the Secretary shall implement the transition  
31 plan under subsection (a) and transfer the administrative  
32 law judge functions described in such subsection from the  
33 Social Security Administration to the Secretary.

34 (2) ASSURING INDEPENDENCE OF JUDGES.—The Sec-  
35 retary shall effect such transfer in a manner that assures  
36 the independence of such judges from the Centers for Medi-  
37 care & Medicaid Services and its contractors.

1           (3) GEOGRAPHIC DISTRIBUTION.—The Secretary shall  
2       provide for an appropriate geographic distribution of such  
3       judges throughout the United States to ensure timely ac-  
4       cess to such judges.

5           (4) HIRING AUTHORITY.—Subject to the amounts pro-  
6       vided in advance in appropriations Act, the Secretary shall  
7       have authority to hire additional administrative law judges  
8       to hear such cases, giving priority to those judges with  
9       prior experience in handling medicare appeals and in a  
10      manner consistent with paragraph (3), and to hire support  
11      staff for such judges.

12          (5) FINANCING.—Amounts payable under law to the  
13      Commissioner for such judges from the Federal Hospital  
14      Insurance Trust Fund and the Federal Supplementary  
15      Medical Insurance Trust Fund shall become payable to the  
16      Secretary for the judges so transferred.

17          (6) SHARED OFFICE SPACE.—The Secretary shall  
18      enter into such arrangements with the Commissioner as  
19      may be appropriate for transferred administrative law  
20      judges to share office space, support staff, and other re-  
21      sources, with appropriate reimbursement from the Trust  
22      Funds described in paragraph (5).

23          (c) INCREASED FINANCIAL SUPPORT.—In addition to any  
24      amounts otherwise appropriated, to ensure timely action on ap-  
25      peals before administrative law judges consistent with section  
26      1869 of the Social Security Act (as amended by section 521  
27      of BIPA, 114 Stat. 2763A–534), there are authorized to be ap-  
28      propriated (in appropriate part from the Federal Hospital In-  
29      surance Trust Fund and the Federal Supplementary Medical  
30      Insurance Trust Fund) to the Secretary to increase the number  
31      of administrative law judges (and their staffs) under subsection  
32      (b)(4) and to improve education and training opportunities for  
33      administrative law judges (and their staffs), such sums as are  
34      necessary for fiscal year 2003 and each subsequent fiscal year.

35          (d) CONFORMING AMENDMENT.—Section 1869(f)(2)(A)(i)  
36      (42 U.S.C. 1395ff(f)(2)(A)(i)), as added by section 522(a) of

1 BIPA 114 Stat. 2763A–543, is amended by striking “of the  
2 Social Security Administration”.

3 **SEC. 202. EXPEDITED ACCESS TO JUDICIAL REVIEW.**

4 (a) IN GENERAL.—Section 1869(b) (42 U.S.C. 1395ff(b)),  
5 as amended by section 521 of BIPA, 114 Stat. 2763A–534, is  
6 amended—

7 (1) in paragraph (1)(A), by inserting “, subject to  
8 paragraph (2),” before “to judicial review of the Sec-  
9 retary’s final decision”; and

10 (2) by adding at the end the following new paragraph:

11 “(2) EXPEDITED ACCESS TO JUDICIAL REVIEW.—

12 “(A) IN GENERAL.—The Secretary shall establish  
13 a process under which a provider of service or supplier  
14 that furnishes an item or service or a beneficiary who  
15 has filed an appeal under paragraph (1) (other than an  
16 appeal filed under paragraph (1)(F)) may obtain access  
17 to judicial review when a review panel (described in  
18 subparagraph (D)), on its own motion or at the request  
19 of the appellant, determines that the Departmental Ap-  
20 peals Board does not have the authority to decide the  
21 question of law or regulation relevant to the matters in  
22 controversy and that there is no material issue of fact  
23 in dispute. The appellant may make such request only  
24 once with respect to a question of law or regulation for  
25 a specific matter in dispute in a case of an appeal.

26 “(B) PROMPT DETERMINATIONS.—If, after or co-  
27 incident with appropriately filing a request for an ad-  
28 ministrative hearing, the appellant requests a deter-  
29 mination by the appropriate review panel that the De-  
30 partmental Appeals Board does not have the authority  
31 to decide the question of law or regulations relevant to  
32 the matters in controversy and that there is no mate-  
33 rial issue of fact in dispute and if such request is ac-  
34 companied by the documents and materials as the ap-  
35 propriate review panel shall require for purposes of  
36 making such determination, such review panel shall  
37 make a determination on the request in writing within

1           60 days after the date such review panel receives the  
2           request and such accompanying documents and mate-  
3           rials. Such a determination by such review panel shall  
4           be considered a final decision and not subject to review  
5           by the Secretary.

6           “(C) ACCESS TO JUDICIAL REVIEW.—

7           “(i) IN GENERAL.—If the appropriate review  
8           panel—

9           “(I) determines that there are no material  
10          issues of fact in dispute and that the only issue  
11          is one of law or regulation that the Depart-  
12          mental Appeals Board does not have authority  
13          to decide; or

14          “(II) fails to make such determination  
15          within the period provided under subparagraph  
16          (B);

17          then the appellant may bring a civil action as de-  
18          scribed in this subparagraph.

19          “(ii) DEADLINE FOR FILING.—Such action  
20          shall be filed, in the case described in—

21          “(I) clause (i)(I), within 60 days of date  
22          of the determination described in such subpara-  
23          graph; or

24          “(II) clause (i)(II), within 60 days of the  
25          end of the period provided under subparagraph  
26          (B) for the determination.

27          “(iii) VENUE.—Such action shall be brought  
28          in the district court of the United States for the ju-  
29          dicial district in which the appellant is located (or,  
30          in the case of an action brought jointly by more  
31          than one applicant, the judicial district in which  
32          the greatest number of applicants are located) or in  
33          the district court for the District of Columbia.

34          “(iv) INTEREST ON ANY AMOUNTS IN CON-  
35          TROVERSY.—Where a provider of services or sup-  
36          plier seeks judicial review pursuant to this para-  
37          graph, the amount in controversy (if any) shall be

1 subject to annual interest beginning on the first  
2 day of the first month beginning after the 60-day  
3 period as determined pursuant to clause (ii) and  
4 equal to the rate of interest on obligations issued  
5 for purchase by the Federal Supplementary Med-  
6 ical Insurance Trust Fund for the month in which  
7 the civil action authorized under this paragraph is  
8 commenced, to be awarded by the reviewing court  
9 in favor of the prevailing party. No interest award-  
10 ed pursuant to the preceding sentence shall be  
11 deemed income or cost for the purposes of deter-  
12 mining reimbursement due providers of services,  
13 physicians, practitioners, facilities, and suppliers  
14 under this Act.

15 “(D) REVIEW PANEL DEFINED.—For purposes of  
16 this subsection, a ‘review panel’ is a panel of 3 mem-  
17 bers from the Departmental Appeals Board, selected  
18 for the purpose of making determinations under this  
19 paragraph.”.

20 (b) APPLICATION TO PROVIDER AGREEMENT DETERMINA-  
21 TIONS.—Section 1866(h)(1) (42 U.S.C. 1395cc(h)(1)) is  
22 amended—

23 (1) by inserting “(A)” after “(h)(1)”; and

24 (2) by adding at the end the following new subpara-  
25 graph:

26 “(B) An institution or agency described in subparagraph  
27 (A) that has filed for a hearing under subparagraph (A) shall  
28 have expedited access to judicial review under this subpara-  
29 graph in the same manner as providers of services, suppliers,  
30 and beneficiaries may obtain expedited access to judicial review  
31 under the process established under section 1869(b)(2). Noth-  
32 ing in this subparagraph shall be construed to affect the appli-  
33 cation of any remedy imposed under section 1819 during the  
34 pendency of an appeal under this subparagraph.”.

35 (c) EFFECTIVE DATE.—The amendments made by this  
36 section shall apply to appeals filed on or after October 1, 2003.

1     **SEC. 203. EXPEDITED REVIEW OF CERTAIN PROVIDER**  
2                   **AGREEMENT DETERMINATIONS.**

3           (a) TERMINATION AND IMMEDIATE SANCTIONS.—The Sec-  
4     retary shall develop and implement a process to expedite pro-  
5     ceedings under sections 1866(h) of the Social Security Act (42  
6     U.S.C. 1395cc(h)) in which the sanction of termination of par-  
7     ticipation or a sanction described in clause (i) or (iii) of section  
8     1819(h)(2)(B) of such Act (42 U.S.C. 1395i-3(h)(2)(B)) has  
9     been imposed. Under such process priority shall be provided in  
10    cases of termination.

11          (b) INCREASED FINANCIAL SUPPORT.—In addition to any  
12    amounts otherwise appropriated, to reduce by 50 percent the  
13    average time for administrative determinations on appeals  
14    under section 1866(h) of the Social Security Act (42 U.S.C.  
15    1395cc(h)), there are authorized to be appropriated (in appro-  
16    priate part from the Federal Hospital Insurance Trust Fund  
17    and the Federal Supplementary Medical Insurance Trust  
18    Fund) to the Secretary such additional sums for fiscal year  
19    2003 and each subsequent fiscal year as may be necessary to  
20    increase the number of administrative law judges (and their  
21    staffs) at the Departmental Appeals Board of the Department  
22    of Health and Human Services and to educate such judges and  
23    staff on long-term care issues.

24     **SEC. 204. REVISIONS TO MEDICARE APPEALS PROCESS.**

25          (a) TIMEFRAMES FOR THE COMPLETION OF THE  
26    RECORD.—Section 1869(b) (42 U.S.C. 1395ff(b)), as amended  
27    by section 521 of BIPA, 114 Stat. 2763A-534, and as amend-  
28    ed in section 202(a), is further amended by adding at the end  
29    the following new paragraph:

30               “(3) TIMELY SUBMISSION OF EVIDENCE.—

31               “(A) DEADLINE FOR SUBMISSION OF EVIDENCE.—  
32    The deadline to complete the record in an appeal is 90  
33    days after the date the request for appeal is filed. The  
34    appellant in such an appeal may request an extension  
35    of such deadline for good cause. The adjudicator may  
36    extend such deadline based upon a finding of good  
37    cause to a date specified by the adjudicator.

1 “(B) DELAY IN DECISION DEADLINES UNTIL COM-  
2 PLETION OF RECORD.—Notwithstanding any other pro-  
3 vision of this section, the deadlines otherwise estab-  
4 lished for the making of determination by adjudicators  
5 under this section shall begin on the date on which the  
6 record is complete.

7 “(C) ADJUDICATOR DEFINED.—For purposes of  
8 this paragraph, the term ‘adjudicator’ means an admin-  
9 istrative law judge (whether or not under the Depart-  
10 mental Appeals Board) and includes an administrative  
11 appeals judge under such Board.”.

12 (b) USE OF PATIENTS’ MEDICAL RECORDS.—Section  
13 1869(c)(3)(B)(i) (42 U.S.C. 1395ff(c)(3)(B)(i)) is amended by  
14 inserting “(including the medical records of the individual in-  
15 volved)” after “clinical experience”.

16 (c) NOTICE REQUIREMENTS FOR MEDICARE APPEALS.—

17 (1) INITIAL DETERMINATIONS AND REDETERMINA-  
18 TIONS.—Section 1869(a) (42 U.S.C. 1395ff(a)) is amended  
19 by adding at the end the following new paragraph:

20 “(4) REQUIREMENTS OF NOTICE OF DETERMINATIONS  
21 AND REDETERMINATIONS.—A written notice of a deter-  
22 mination on an initial determination or on a redetermina-  
23 tion, insofar as such determination or redetermination re-  
24 sults in a denial of a claim for benefits, shall be provided  
25 in printed form and written in a manner calculated to be  
26 understood by the beneficiary and shall include—

27 “(A) the specific reasons for the determination, in-  
28 cluding, as appropriate—

29 “(i) upon request in the case of an initial de-  
30 termination, a summary of the clinical or scientific  
31 evidence used in making the determination; and

32 “(ii) in the case of a redetermination, such a  
33 summary;

34 “(B) the procedures for obtaining additional infor-  
35 mation concerning the determination or redetermina-  
36 tion; and

1 “(C) notification of the right to seek a redeter-  
2 mination or otherwise appeal the determination and in-  
3 structions on how to initiate such a redetermination or  
4 appeal under this section.”.

5 (2) RECONSIDERATIONS.—Section 1869(c)(3)(E) (42  
6 U.S.C. 1395ff(c)(3)(E)) is amended—

7 (A) by inserting “be written in a manner cal-  
8 culated to be understood by the beneficiary, and shall  
9 include (to the extent appropriate)” after “in writing,  
10 ”; and

11 (B) by inserting “and a notification of the right to  
12 appeal such determination and instructions on how to  
13 initiate such appeal under this section” after “such de-  
14 cision, ”.

15 (3) APPEALS.—Section 1869(d) (42 U.S.C. 1395ff(d))  
16 is amended—

17 (A) in the heading, by inserting “; NOTICE” after  
18 “SECRETARY”; and

19 (B) by adding at the end the following new para-  
20 graph:

21 “(4) NOTICE.—Notice of the decision of an adminis-  
22 trative law judge shall be in writing in a manner calculated  
23 to be understood by the beneficiary and shall include—

24 “(A) the specific reasons for the determination (in-  
25 cluding, to the extent appropriate, a summary of the  
26 clinical or scientific evidence used in making the deter-  
27 mination);

28 “(B) the procedures for obtaining additional infor-  
29 mation concerning the decision; and

30 “(C) notification of the right to appeal the deci-  
31 sion and instructions on how to initiate such an appeal  
32 under this section.”.

33 (4) PREPARATION OF RECORD FOR APPEAL.—Section  
34 1869(c)(3)(J) (42 U.S.C. 1395ff(c)(3)(J)) by striking  
35 “such information as is required for an appeal” and insert-  
36 ing “the record for the appeal”.

37 (d) QUALIFIED INDEPENDENT CONTRACTORS.—

(1) ELIGIBILITY REQUIREMENTS OF QUALIFIED INDEPENDENT CONTRACTORS.—Section 1869(c) (42 U.S.C. 1395ff(c)) is amended—

(A) in paragraph (2)—

(i) by inserting “(except in the case of a utilization and quality control peer review organization, as defined in section 1152)” after “means an entity or organization that”; and

(ii) by striking the period at the end and inserting the following: “and meets the following requirements:

“(A) GENERAL REQUIREMENTS.—

“(i) The entity or organization has (directly or through contracts or other arrangements) sufficient medical, legal, and other expertise (including knowledge of the program under this title) and sufficient staffing to carry out duties of a qualified independent contractor under this section on a timely basis.

“(ii) The entity or organization has provided assurances that it will conduct activities consistent with the applicable requirements of this section, including that it will not conduct any activities in a case unless the independence requirements of subparagraph (B) are met with respect to the case.

“(iii) The entity or organization meets such other requirements as the appropriate Secretary provides by regulation.

“(B) INDEPENDENCE REQUIREMENTS.—

“(i) IN GENERAL.—Subject to clause (ii), an entity or organization meets the independence requirements of this subparagraph with respect to any case if the entity—

“(I) is not a related party (as defined in subsection (g)(5));

“(II) does not have a material familial, financial, or professional relationship with such a party in relation to such case; and

“(III) does not otherwise have a conflict of interest with such a party (as determined under regulations).

“(ii) EXCEPTION FOR REASONABLE COMPENSATION.—Nothing in clause (i) shall be construed to prohibit receipt by a qualified independent contractor of compensation from the Secretary for the conduct of activities under this section if the compensation is provided consistent with clause (iii).

“(iii) LIMITATIONS ON ENTITY COMPENSATION.—Compensation provided by the Secretary to a qualified independent contractor in connection with reviews under this section shall—

“(I) not exceed a reasonable level; and

“(II) not be contingent on any decision rendered by the contractor or by any reviewing professional.”; and

(B) in paragraph (3)(A), by striking “, and shall have sufficient training and expertise in medical science and legal matters to make reconsiderations under this subsection”.

(2) ELIGIBILITY REQUIREMENTS FOR REVIEWERS.—Section 1869 (42 U.S.C. 1395ff) is amended—

(A) by amending subsection (c)(3)(D) to read as follows:

“(D) QUALIFICATIONS FOR REVIEWERS.—The requirements of subsection (g) shall be met (relating to qualifications of reviewing professionals).”; and

(B) by adding at the end the following new subsection:

“(g) QUALIFICATIONS OF REVIEWERS.—

1 “(1) IN GENERAL.—In reviewing determinations under  
2 this section, a qualified independent contractor shall assure  
3 that—

4 “(A) each individual conducting a review shall  
5 meet the qualifications of paragraph (2);

6 “(B) compensation provided by the contractor to  
7 each such reviewer is consistent with paragraph (3);  
8 and

9 “(C) in the case of a review by a panel described  
10 in subsection (c)(3)(B) composed of physicians or other  
11 health care professionals (each in this subsection re-  
12 ferred to as a ‘reviewing professional’), each reviewing  
13 professional meets the qualifications described in para-  
14 graph (4).

15 “(2) INDEPENDENCE.—

16 “(A) IN GENERAL.—Subject to subparagraph (B),  
17 each individual conducting a review in a case shall—

18 “(i) not be a related party (as defined in para-  
19 graph (5));

20 “(ii) not have a material familial, financial, or  
21 professional relationship with such a party in the  
22 case under review; and

23 “(iii) not otherwise have a conflict of interest  
24 with such a party (as determined under regula-  
25 tions).

26 “(B) EXCEPTION.—Nothing in subparagraph (A)  
27 shall be construed to—

28 “(i) prohibit an individual, solely on the basis  
29 of affiliation with a fiscal intermediary, carrier, or  
30 other contractor, from serving as an reviewing pro-  
31 fessional if—

32 “(I) a non-affiliated individual is not rea-  
33 sonably available;

34 “(II) the affiliated individual is not in-  
35 volved in the provision of items or services in  
36 the case under review;

“(III) the fact of such an affiliation is disclosed to the Secretary and the beneficiary (or authorized representative) and neither party objects; and

“(IV) the affiliated individual is not an employee of the intermediary, carrier, or contractor and does not provide services exclusively or primarily to or on behalf of such intermediary, carrier, or contractor;

“(ii) prohibit an individual who has staff privileges at the institution where the treatment involved takes place from serving as a reviewer merely on the basis of such affiliation if the affiliation is disclosed to the Secretary and the beneficiary (or authorized representative), and neither party objects; or

“(iii) prohibit receipt of compensation by a reviewing professional from a contractor if the compensation is provided consistent with paragraph (3).

“(3) LIMITATIONS ON REVIEWER COMPENSATION.—Compensation provided by a qualified independent contractor to a reviewer in connection with a review under this section shall—

“(A) not exceed a reasonable level; and

“(B) not be contingent on the decision rendered by the reviewer.

“(4) LICENSURE AND EXPERTISE.—Each reviewing professional shall be a physician (allopathic or osteopathic) or health care professional who—

“(A) is appropriately credentialed or licensed in 1 or more States to deliver health care services; and

“(B) typically treats the condition, makes the diagnosis, or provides the type of treatment under review.

“(5) RELATED PARTY DEFINED.—For purposes of this section, the term ‘related party’ means, with respect to a

1 case under this title involving an individual beneficiary, any  
2 of the following:

3 “(A) The Secretary, the fiscal intermediary or car-  
4 rier involved, or any fiduciary, officer, director, or em-  
5 ployee of the Department of Health and Human Serv-  
6 ices, or of such intermediary or carrier.

7 “(B) The individual (or authorized representative).

8 “(C) The health care professional that provides  
9 the items or services involved in the case.

10 “(D) The institution at which the items or services  
11 (or treatment) involved in the case are provided.

12 “(E) The manufacturer of any drug or other item  
13 that is included in the items or services involved in the  
14 case.

15 “(F) Any other party determined under any regu-  
16 lations to have a substantial interest in the case in-  
17 volved.”.

18 (e) IMPLEMENTATION OF CERTAIN BIPA REFORMS.—

19 (1) Section 521 of BIPA (114 Stat. 2763A–543) is  
20 amended—

21 (A) in subsection (c), by striking “and (4)” and  
22 inserting “(4), and (5)”;

23 (B) in subsection (d), by striking “October 1,  
24 2002” and inserting “October 1, 2003”; and

25 (C) by adding at the end the following new sub-  
26 section: I20 “(e) USE OF PRO PROCESS FOR RE-  
27 VIEW OF TERMINATIONS AND DISCHARGES DURING  
28 TRANSITION PERIOD.—

29 “(1) IN GENERAL.—In the case of an individual who  
30 receives a notice of termination or discharge described in  
31 paragraph (2) during the transition period described in  
32 paragraph (3), the individual may request, in writing or  
33 orally, an expedited review of the termination or discharge  
34 under section 1154(e) of the Social Security Act (as in ef-  
35 fect before the the date of the enactment of this Act, but  
36 applying the provisions of paragraph (4)). Such review is  
37 in place of a review of the termination or discharge by a

1 qualified independent contractor under section 1869 of the  
2 Social Security Act, as amended by subsection (a).

3 “(2) NOTICES DESCRIBED.—For purposes of this sub-  
4 section, a notice described in this paragraph is a notice of  
5 termination or discharge from a provider of services that  
6 the provider of services plans under title XVIII of the So-  
7 cial Security Act—

8 “(A) to terminate services provided to an indi-  
9 vidual and a physician certifies that failure to continue  
10 the provision of such services is likely to place the indi-  
11 vidual’s health at significant risk; or

12 “(B) to discharge the individual from the provider  
13 of services.

14 “(3) TRANSITION PERIOD.—The transition period  
15 described in this paragraph, with respect to an individual  
16 who resides in an area served by a utilization and quality  
17 control peer review organization under part C of title XI  
18 of the Social Security Act—

19 “(A) begins on the date on which the last triennial  
20 contract with any utilization and quality control peer  
21 review organization under such part becomes effective  
22 during 2002; and

23 “(B) ends on the date that the triennial contract  
24 under such part with the peer review organization that  
25 serves such area expires in 2005.

26 The Secretary shall provide for an appropriate transfer of  
27 the hearing functions described in paragraph (1) from peer  
28 review organizations under this subsection to qualified inde-  
29 pendent contractors under section 1869.

30 “(4) RULES OF APPLICATION.—In applying section  
31 1154(e) of the Social Security Act under paragraph (1)—

32 “(A) any reference in such section—

33 “(i) to a hospital is deemed a reference to a  
34 provider of services;

35 “(ii) to inpatient hospital care or services is  
36 deemed a reference to services of such a provider  
37 of services;

1 “(iii) a notice under paragraph (1) is deemed  
2 a reference to the notice described in paragraph (2)  
3 of this subsection; and

4 “(iv) an inpatient is deemed a reference to a  
5 patient;

6 “(B) paragraph (1) of such section 1154(e) shall  
7 not apply; and

8 “(C) the provisions of section 1869(b)(1)(F)(ii) of  
9 such Act (as amended by subsection (a)) (relating to  
10 expedited hearings) shall apply to the review under this  
11 subsection except that any reference in such section to  
12 the Secretary or a hearing under this subsection shall  
13 be deemed a reference to a peer review organization  
14 and a review under such section 1154(e).”.

15 (2) Section 1869(b)(1)(F) (42 U.S.C.  
16 1395ff(b)(1)(F)), as amended by section 521 of BIPA, is  
17 amended by adding at the end the following new clause:

18 “(iii) TRANSITION.—The Secretary shall not  
19 provide for an expedited determination or redeter-  
20 mination by a qualified independent contractor with  
21 respect to a notice of termination or discharge  
22 under this subparagraph if section 521(e) of the  
23 Medicare, Medicaid, and SCHIP Benefits Improve-  
24 ment and Protection Act of 2000 provides for the  
25 performance of an expedited review with respect to  
26 such a notice by a utilization and quality control  
27 peer review organization.”.

28 (3) Section 522(d) of BIPA (114 Stat. 2763A–547) is  
29 amended by striking “October 1, 2001” and inserting “Oc-  
30 tober 1, 2002”.

31 (f) EFFECTIVE DATE.—The amendments made by this  
32 section shall be effective as if included in the enactment of the  
33 respective provisions of subtitle C of title V of BIPA, 114 Stat.  
34 2763A–534.

1   **SEC. 205. HEARING RIGHTS RELATED TO DECISIONS BY**  
2                   **THE SECRETARY TO DENY OR NOT RENEW A**  
3                   **MEDICARE ENROLLMENT AGREEMENT.**

4           (a) HEARING RIGHTS.—Section 1866 (42 U.S.C. 1395cc)  
5 is amended by adding at the end the following new subsection:

6           “(j) HEARING RIGHTS IN CASES OF DENIAL OR NON-RE-  
7 NEWAL.—A provider of services, physician, practitioner, facil-  
8 ity, or supplier whose application to enroll (or, if applicable, to  
9 renew enrollment) under this title is denied may have a hearing  
10 and judicial review of such denial under the procedures that  
11 apply under subsection (h)(1)(A) to a provider of services that  
12 is dissatisfied with a determination by the Secretary.”.

13          (b) EFFECTIVE DATE.—The amendment made by sub-  
14 section (a) shall apply to denials occurring on or after such  
15 date (not later than 6 months after the date of the enactment  
16 of this Act) as the Secretary specifies.

17   **SEC. 206. APPEALS BY PROVIDERS WHEN THERE IS NO**  
18                   **OTHER PARTY AVAILABLE.**

19          (a) IN GENERAL.—Section 1870 (42 U.S.C. 1395gg) is  
20 amended by adding at the end the following new subsection:

21          “(h) Notwithstanding subsection (f) or any other provision  
22 of law, the Secretary shall permit a provider of services, physi-  
23 cian, practitioner, facility, or supplier to appeal any determina-  
24 tion of the Secretary under this title relating to services ren-  
25 dered under this title to an individual who subsequently dies,  
26 if there is no other party available to appeal such determina-  
27 tion, so long as the estate of the individual, and the individual’s  
28 family and heirs, are not liable for paying for the item or serv-  
29 ice and are not liable for any increased coinsurance or deduct-  
30 ible amounts resulting from any decision increasing the reim-  
31 bursement amount for the provider of services, physician, prac-  
32 titioner, facility, or supplier.”.

33          (b) EFFECTIVE DATE.—The amendment made by sub-  
34 section (a) shall take effect on the date of the enactment of this  
35 Act and shall apply to items and services furnished on or after  
36 such date.

1   **SEC. 207. PROCESS FOR EXCEPTIONS TO NATIONAL**  
2                   **COVERAGE DETERMINATIONS UNDER SPE-**  
3                   **CIAL MEDICAL CIRCUMSTANCES.**

4           (a) IN GENERAL.—Section 1869(f) (42 U.S.C. 1395ff(f)),  
5 as added by section 522 of BIPA, is amended—

6           (1) by redesignating paragraphs (6) through (8) as  
7 paragraphs (7) through (9); and

8           (2) by inserting after paragraph (5) the following new  
9 paragraph:

10           “(6) PROCESS FOR EXCEPTIONS TO NATIONAL COV-  
11 ERAGE DETERMINATIONS UNDER SPECIAL MEDICAL CIR-  
12 CUMSTANCES.—

13           “(A) ESTABLISHMENT OF PROCESS.—The Sec-  
14 retary shall establish a process whereby an individual  
15 described in paragraph (5) may submit to the Sec-  
16 retary a request for a determination that a national  
17 coverage determination, which has the effect of denying  
18 coverage under this title for items and services for the  
19 treatment of a serious or life-threatening condition of  
20 the individual, should not apply to the individual due  
21 to the special medical circumstances of the individual  
22 that involve medical factors that were not considered  
23 during the national coverage determination decision-  
24 making procedure and make the application of the na-  
25 tional coverage determination inappropriate for the in-  
26 dividual’s particular case. Such request shall be accom-  
27 panied by supporting documentation and may be made  
28 before the receipt of the items or services involved.

29           “(B) USE OF PANEL.—Under such process, the  
30 Secretary shall provide that—

31           “(i) the initial decision on the request is made  
32 by a panel described in subparagraph (C); or

33           “(ii) the individual is provided the opportunity  
34 to appeal the initial decision on the request to such  
35 a panel.

36           “(C) PANEL.—A panel described in this subpara-  
37 graph is a panel of physicians or other appropriate

1 health care professionals in which each member of the  
2 panel meets the requirements of paragraphs (2) and  
3 (4) of subsection (g) (relating to independence and li-  
4 censure and expertise).

5 “(D) APPEAL.—A decision on a request under this  
6 paragraph shall be subject to further review (after any  
7 appeal described in subparagraph (B)(ii)) by the De-  
8 partmental Appeals Board and to judicial review, in the  
9 same manner as provided under subsection (b) with re-  
10 spect to review of a final decision of the Secretary.

11 “(E) EXPEDITION.—The process under this para-  
12 graph shall provide for reasonable expedition for mak-  
13 ing decisions on requests when the need for expedition  
14 is certified by a physician.

15 “(F) EFFECT OF DECISION.—If a request under  
16 this paragraph is approved for an individual with re-  
17 spect to a treatment, the national coverage determina-  
18 tion shall not be applied by any medicare administra-  
19 tive contractor with respect to the treatment for that  
20 individual.

21 “(G) NOTICE.—The Secretary shall provide, in an  
22 appropriate annual publication available to the public,  
23 a list of national coverage determinations and informa-  
24 tion on how to get more information with respect to  
25 such determinations, made in the previous year.”.

26 (b) EFFECTIVE DATE.—The amendments made by sub-  
27 section (a) shall apply as if included in the enactment of sec-  
28 tion 522 of BIPA.

29 **SEC. 208. BIPA-RELATED TECHNICAL AMENDMENTS AND**  
30 **CORRECTIONS.**

31 (a) TECHNICAL AMENDMENTS RELATING TO ADVISORY  
32 COMMITTEE UNDER BIPA SECTION 522.—(1) Subsection (i) of  
33 section 1114 (42 U.S.C. 1314)—

34 (A) is transferred to section 1862 and added at the  
35 end of such section; and

36 (B) is redesignated as subsection (j).

37 (2) Section 1862 (42 U.S.C. 1395y) is amended—

1 (A) in the last sentence of subsection (a), by striking  
2 “section 1114(f)” and inserting “section 222 of the Public  
3 Health Service Act”; and

4 (B) in subsection (j), as so transferred and  
5 redesignated—

6 (i) by striking “subsection (f)” and inserting “sec-  
7 tion 222 of the Public Health Service Act”;

8 (ii) by striking “section 1862(a)(1)” and inserting  
9 “subsection (a)(1)”.

10 (b) TERMINOLOGY CORRECTIONS.—(1) Section  
11 1869(c)(3)(I)(ii) (42 U.S.C. 1395ff(c)(3)(I)(ii)), as amended by  
12 section 521 of BIPA, is amended—

13 (A) in subclause (III), by striking “policy” and insert-  
14 ing “determination”; and

15 (B) in subclause (IV), by striking “medical review  
16 policies” and inserting “coverage determinations”.

17 (2) Section 1852(a)(2)(C) (42 U.S.C. 1395w-22(a)(2)(C))  
18 is amended by striking “policy” and inserting “determination”  
19 both places it appears.

20 (c) REFERENCE CORRECTIONS.—Section 1869(f)(4) (42  
21 U.S.C. 1395ff(f)(4)), as added by section 522 of BIPA, is  
22 amended—

23 (1) in subparagraph (A)(iv), by striking “subclause  
24 (I), (II), or (III)” and inserting “clause (i), (ii), or (iii)”;

25 (2) in subparagraph (B), by striking “clause (i)(IV)”  
26 and “clause (i)(III)” and inserting “subparagraph (A)(iv)”  
27 and “subparagraph (A)(iii)”, respectively; and

28 (3) in subparagraph (C), by striking “clause (i)”,  
29 “subclause (IV)” and “subparagraph (A)” and inserting  
30 “subparagraph (A)”, “clause (iv)” and “paragraph  
31 (1)(A)”, respectively each place it appears.

32 (d) EFFECTIVE DATE.—The amendments made by this  
33 section shall be effective as if included in the enactment of  
34 BIPA.

1     **TITLE III—CONTRACTING REFORM**

2     **SEC. 301. INCREASED FLEXIBILITY IN MEDICARE AD-**  
3     **MINISTRATION.**

4         (a) CONSOLIDATION AND FLEXIBILITY IN MEDICARE AD-  
5     MINISTRATION.—

6             (1) IN GENERAL.—Title XVIII is amended by insert-  
7     ing after section 1874 the following new section:

8     “CONTRACTS WITH MEDICARE ADMINISTRATIVE CONTRACTORS

9         “SEC. 1874A. (a) AUTHORITY.—

10            “(1) AUTHORITY TO ENTER INTO CONTRACTS.—The  
11     Secretary may enter into contracts with any eligible entity  
12     to serve as a medicare administrative contractor with re-  
13     spect to the performance of any or all of the functions de-  
14     scribed in paragraph (4) or parts of those functions (or, to  
15     the extent provided in a contract, to secure performance  
16     thereof by other entities).

17            “(2) ELIGIBILITY OF ENTITIES.—An entity is eligible  
18     to enter into a contract with respect to the performance of  
19     a particular function or activity described in paragraph (4)  
20     only if—

21                 “(A) the entity has demonstrated capability to  
22     carry out such function;

23                 “(B) the entity complies with such conflict of in-  
24     terest standards as are generally applicable to Federal  
25     acquisition and procurement;

26                 “(C) the entity has sufficient assets to financially  
27     support the performance of such function; and

28                 “(D) the entity meets such other requirements as  
29     the Secretary may impose.

30            “(3) MEDICARE ADMINISTRATIVE CONTRACTOR DE-  
31     FINED.—For purposes of this title and title XI—

32                 “(A) IN GENERAL.—The term ‘medicare adminis-  
33     trative contractor’ means an agency, organization, or  
34     other person with a contract under this section.

35                 “(B) APPROPRIATE MEDICARE ADMINISTRATIVE  
36     CONTRACTOR.—With respect to the performance of a  
37     particular function or activity in relation to an indi-

vidual entitled to benefits under part A or enrolled under part B, or both, a specific provider of services, physician, practitioner, facility, or supplier (or class of such providers of services, physicians, practitioners, facilities, or suppliers), the ‘appropriate’ medicare administrative contractor is the medicare administrative contractor that has a contract under this section with respect to the performance of that function or activity in relation to that individual, provider of services, physician, practitioner, facility, or supplier or class of provider of services, physician, practitioner, facility, or supplier.

“(4) FUNCTIONS DESCRIBED.—The functions referred to in paragraphs (1) and (2) are payment functions, provider services functions, and beneficiary services functions as follows:

“(A) DETERMINATION OF PAYMENT AMOUNTS.—Determining (subject to the provisions of section 1878 and to such review by the Secretary as may be provided for by the contracts) the amount of the payments required pursuant to this title to be made to providers of services, physicians, practitioners, facilities, suppliers, and individuals.

“(B) MAKING PAYMENTS.—Making payments described in subparagraph (A) (including receipt, disbursement, and accounting for funds in making such payments).

“(C) BENEFICIARY EDUCATION AND ASSISTANCE.—Serving as a center for, and communicating to individuals entitled to benefits under part A or enrolled under part B, or both, with respect to education and outreach for those individuals, and assistance with specific issues, concerns or problems of those individuals.

“(D) PROVIDER CONSULTATIVE SERVICES.—Providing consultative services to institutions, agencies, and other persons to enable them to establish and maintain fiscal records necessary for purposes of this

1 title and otherwise to qualify as providers of services,  
2 physicians, practitioners, facilities, or suppliers.

3 “(E) COMMUNICATION WITH PROVIDERS.—Serving  
4 as a center for, and communicating to providers of  
5 services, physicians, practitioners, facilities, and sup-  
6 pliers, any information or instructions furnished to the  
7 medicare administrative contractor by the Secretary,  
8 and serving as a channel of communication from such  
9 providers, physicians, practitioners, facilities, and sup-  
10 pliers to the Secretary.

11 “(F) PROVIDER EDUCATION AND TECHNICAL AS-  
12 SISTANCE.—Performing the functions described in sub-  
13 sections (e) and (f), relating to education, training, and  
14 technical assistance to providers of services, physicians,  
15 practitioners, facilities, and suppliers.

16 “(G) ADDITIONAL FUNCTIONS.—Performing such  
17 other functions as are necessary to carry out the pur-  
18 poses of this title.

19 “(5) RELATIONSHIP TO MIP CONTRACTS.—

20 “(A) NONDUPLICATION OF DUTIES.—In entering  
21 into contracts under this section, the Secretary shall  
22 assure that functions of medicare administrative con-  
23 tractors in carrying out activities under parts A and B  
24 do not duplicate functions carried out under the Medi-  
25 care Integrity Program under section 1893. The pre-  
26 vious sentence shall not apply with respect to the activ-  
27 ity described in section 1893(b)(5) (relating to prior  
28 authorization of certain items of durable medical equip-  
29 ment under section 1834(a)(15)).

30 “(B) CONSTRUCTION.—An entity shall not be  
31 treated as a medicare administrative contractor merely  
32 by reason of having entered into a contract with the  
33 Secretary under section 1893.

34 “(6) APPLICATION OF FEDERAL ACQUISITION REGULA-  
35 TION.—Except to the extent inconsistent with a specific re-  
36 quirement of this title, the Federal Acquisition Regulation  
37 applies to contracts under this title.

1 “(b) CONTRACTING REQUIREMENTS.—

2 “(1) USE OF COMPETITIVE PROCEDURES.—

3 “(A) IN GENERAL.—Except as provided in laws  
4 with general applicability to Federal acquisition and  
5 procurement or in subparagraph (B), the Secretary  
6 shall use competitive procedures when entering into  
7 contracts with medicare administrative contractors  
8 under this section.

9 “(B) RENEWAL OF CONTRACTS.—The Secretary  
10 may renew a contract with a medicare administrative  
11 contractor under this section from term to term with-  
12 out regard to section 5 of title 41, United States Code,  
13 or any other provision of law requiring competition, if  
14 the medicare administrative contractor has met or ex-  
15 ceeded the performance requirements applicable with  
16 respect to the contract and contractor, except that the  
17 Secretary shall provide for the application of competi-  
18 tive procedures under such a contract not less fre-  
19 quently than once every five years.

20 “(C) TRANSFER OF FUNCTIONS.—The Secretary  
21 may transfer functions among medicare administrative  
22 contractors without regard to any provision of law re-  
23 quiring competition. The Secretary shall ensure that  
24 performance quality is considered in such transfers.  
25 The Secretary shall provide notice (whether in the Fed-  
26 eral Register or otherwise) of any such transfer (includ-  
27 ing a description of the functions so transferred and  
28 contact information for the contractors involved) to  
29 providers of services, physicians, practitioners, facili-  
30 ties, and suppliers affected by the transfer.

31 “(D) INCENTIVES FOR QUALITY.—The Secretary  
32 shall provide incentives for medicare administrative  
33 contractors to provide quality service and to promote  
34 efficiency.

35 “(2) COMPLIANCE WITH REQUIREMENTS.—No con-  
36 tract under this section shall be entered into with any  
37 medicare administrative contractor unless the Secretary

1 finds that such medicare administrative contractor will per-  
2 form its obligations under the contract efficiently and effec-  
3 tively and will meet such requirements as to financial re-  
4 sponsibility, legal authority, and other matters as the Sec-  
5 retary finds pertinent.

6 “(3) PERFORMANCE REQUIREMENTS.—

7 “(A) DEVELOPMENT OF SPECIFIC PERFORMANCE  
8 REQUIREMENTS.—The Secretary shall develop contract  
9 performance requirements to carry out the specific re-  
10 quirements applicable under this title to a function de-  
11 scribed in subsection (a)(4) and shall develop standards  
12 for measuring the extent to which a contractor has met  
13 such requirements. The Secretary shall publish in the  
14 Federal Register such performance requirements and  
15 measurement standards.

16 “(B) CONSIDERATIONS.—The Secretary may in-  
17 clude as one of the standards satisfaction level as  
18 measured by provider and beneficiary surveys.

19 “(C) INCLUSION IN CONTRACTS.—All contractor  
20 performance requirements shall be set forth in the con-  
21 tract between the Secretary and the appropriate medi-  
22 care administrative contractor. Such performance  
23 requirements—

24 “(i) shall reflect the performance requirements  
25 published under subparagraph (A), but may include  
26 additional performance requirements;

27 “(ii) shall be used for evaluating contractor  
28 performance under the contract; and

29 “(iii) shall be consistent with the written state-  
30 ment of work provided under the contract.

31 “(4) INFORMATION REQUIREMENTS.—The Secretary  
32 shall not enter into a contract with a medicare administra-  
33 tive contractor under this section unless the contractor  
34 agrees—

35 “(A) to furnish to the Secretary such timely infor-  
36 mation and reports as the Secretary may find nec-  
37 essary in performing his functions under this title; and

1           “(B) to maintain such records and afford such ac-  
2           cess thereto as the Secretary finds necessary to assure  
3           the correctness and verification of the information and  
4           reports under subparagraph (A) and otherwise to carry  
5           out the purposes of this title.

6           “(5) SURETY BOND.—A contract with a medicare ad-  
7           ministrative contractor under this section may require the  
8           medicare administrative contractor, and any of its officers  
9           or employees certifying payments or disbursing funds pur-  
10          suant to the contract, or otherwise participating in carrying  
11          out the contract, to give surety bond to the United States  
12          in such amount as the Secretary may deem appropriate.

13          “(c) TERMS AND CONDITIONS.—

14          “(1) IN GENERAL.—A contract with any medicare ad-  
15          ministrative contractor under this section may contain such  
16          terms and conditions as the Secretary finds necessary or  
17          appropriate and may provide for advances of funds to the  
18          medicare administrative contractor for the making of pay-  
19          ments by it under subsection (a)(4)(B).

20          “(2) PROHIBITION ON MANDATES FOR CERTAIN DATA  
21          COLLECTION.—The Secretary may not require, as a condi-  
22          tion of entering into, or renewing, a contract under this  
23          section, that the medicare administrative contractor match  
24          data obtained other than in its activities under this title  
25          with data used in the administration of this title for pur-  
26          poses of identifying situations in which the provisions of  
27          section 1862(b) may apply.

28          “(d) LIMITATION ON LIABILITY OF MEDICARE ADMINIS-  
29          TRATIVE CONTRACTORS AND CERTAIN OFFICERS.—

30          “(1) CERTIFYING OFFICER.—No individual designated  
31          pursuant to a contract under this section as a certifying of-  
32          ficer shall, in the absence of gross negligence or intent to  
33          defraud the United States, be liable with respect to any  
34          payments certified by the individual under this section.

35          “(2) DISBURSING OFFICER.—No disbursing officer  
36          shall, in the absence of gross negligence or intent to de-  
37          fraud the United States, be liable with respect to any pay-

1       ment by such officer under this section if it was based upon  
2       an authorization (which meets the applicable requirements  
3       for such internal controls established by the Comptroller  
4       General) of a certifying officer designated as provided in  
5       paragraph (1) of this subsection.

6       “(3) LIABILITY OF MEDICARE ADMINISTRATIVE CON-  
7       TRACTOR.—A medicare administrative contractor shall be  
8       liable to the United States for a payment referred to in  
9       paragraph (1) or (2) if, in connection with such payment,  
10      an individual referred to in either such paragraph acted  
11      with gross negligence or intent to defraud the United  
12      States.

13      “(4) LIMITATION ON CIVIL LIABILITY.—

14      “(A) IN GENERAL.—No medicare administrative  
15      contractor having a contract with the Secretary under  
16      this section, and no person employed by, or having a  
17      fiduciary relationship with, any such medicare adminis-  
18      trative contractor or who furnishes professional services  
19      to such medicare administrative contractor, shall by  
20      reason of the performance of any duty, function, or ac-  
21      tivity required or authorized pursuant to this section or  
22      to a valid contract entered into under this section, be  
23      held civilly liable under any law of the United States  
24      or of any State (or political subdivision thereof), absent  
25      a finding of gross negligence or intent to defraud the  
26      United States in the performance of such duty, func-  
27      tion, or activity.

28      “(B) REIMBURSEMENT OF CERTAIN EXPENSES.—  
29      The Secretary shall make payment to a medicare ad-  
30      ministrative contractor under contract with the Sec-  
31      retary pursuant to this section, or to any member or  
32      employee thereof, or to any person who furnishes legal  
33      counsel or services to such medicare administrative con-  
34      tractor, in an amount equal to the reasonable amount  
35      of the expenses incurred, as determined by the Sec-  
36      retary, in connection with the defense of any civil suit,  
37      action, or proceeding brought against such medicare

1 administrative contractor or person related to the per-  
2 formance of any duty, function, or activity under such  
3 contract, absent a finding of gross negligence or intent  
4 to defraud the United States in the performance of  
5 such duty, function, or activity.”.

6 (2) CONSIDERATION OF INCORPORATION OF CURRENT  
7 LAW STANDARDS.—In developing contract performance re-  
8 quirements under section 1874A(b) of the Social Security  
9 Act, as inserted by paragraph (1), the Secretary shall con-  
10 sider inclusion of the performance standards described in  
11 sections 1816(f)(2) of such Act (relating to timely proc-  
12 essing of reconsiderations and applications for exemptions)  
13 and section 1842(b)(2)(B) of such Act (relating to timely  
14 review of determinations and fair hearing requests), as  
15 such sections were in effect before the date of the enact-  
16 ment of this Act.

17 (b) CONFORMING AMENDMENTS TO SECTION 1816 (RE-  
18 LATING TO FISCAL INTERMEDIARIES).—Section 1816 (42  
19 U.S.C. 1395h) is amended as follows:

20 (1) The heading is amended to read as follows:

21 “PROVISIONS RELATING TO THE ADMINISTRATION OF PART A”.

22 (2) Subsection (a) is amended to read as follows:

23 “(a) The administration of this part shall be conducted  
24 through contracts with medicare administrative contractors  
25 under section 1874A.”.

26 (3) Subsection (b) is repealed.

27 (4) Subsection (c) is amended—

28 (A) by striking paragraph (1); and

29 (B) in each of paragraphs (2)(A) and (3)(A), by  
30 striking “agreement under this section” and inserting  
31 “contract under section 1874A that provides for mak-  
32 ing payments under this part”.

33 (5) Subsections (d) through (i) are repealed.

34 (6) Subsections (j) and (k) are each amended—

35 (A) by striking “An agreement with an agency or  
36 organization under this section” and inserting “A con-  
37 tract with a medicare administrative contractor under

1 section 1874A with respect to the administration of  
2 this part”; and

3 (B) by striking “such agency or organization” and  
4 inserting “such medicare administrative contractor”  
5 each place it appears.

6 (7) Subsection (l) is repealed.

7 (c) CONFORMING AMENDMENTS TO SECTION 1842 (RE-  
8 LATING TO CARRIERS).—Section 1842 (42 U.S.C. 1395u) is  
9 amended as follows:

10 (1) The heading is amended to read as follows:

11 “PROVISIONS RELATING TO THE ADMINISTRATION OF PART B”.

12 (2) Subsection (a) is amended to read as follows:

13 “(a) The administration of this part shall be conducted  
14 through contracts with medicare administrative contractors  
15 under section 1874A.”.

16 (3) Subsection (b) is amended—

17 (A) by striking paragraph (1);

18 (B) in paragraph (2)—

19 (i) by striking subparagraphs (A) and (B);

20 (ii) in subparagraph (C), by striking “car-  
21 riers” and inserting “medicare administrative con-  
22 tractors”; and

23 (iii) by striking subparagraphs (D) and (E);

24 (C) in paragraph (3)—

25 (i) in the matter before subparagraph (A), by  
26 striking “Each such contract shall provide that the  
27 carrier” and inserting “The Secretary”;

28 (ii) by striking “will” the first place it appears  
29 in each of subparagraphs (A), (B), (F), (G), (H),  
30 and (L) and inserting “shall”;

31 (iii) in subparagraph (B), in the matter before  
32 clause (i), by striking “to the policyholders and  
33 subscribers of the carrier” and inserting “to the  
34 policyholders and subscribers of the medicare ad-  
35 ministrative contractor”;

36 (iv) by striking subparagraphs (C), (D), and  
37 (E);

- 1 (v) in subparagraph (H)—  
2 (I) by striking “if it makes determinations  
3 or payments with respect to physicians’ serv-  
4 ices,”; and  
5 (II) by striking “carrier” and inserting  
6 “medicare administrative contractor”;  
7 (vi) by striking subparagraph (I);  
8 (vii) in subparagraph (L), by striking the  
9 semicolon and inserting a period;  
10 (viii) in the first sentence, after subparagraph  
11 (L), by striking “and shall contain” and all that  
12 follows through the period; and  
13 (ix) in the seventh sentence, by inserting  
14 “medicare administrative contractor,” after “car-  
15 rier,”; and  
16 (D) by striking paragraph (5);  
17 (E) in paragraph (6)(D)(iv), by striking “carrier”  
18 and inserting “medicare administrative contractor”;  
19 and  
20 (F) in paragraph (7), by striking “the carrier”  
21 and inserting “the Secretary” each place it appears.  
22 (4) Subsection (c) is amended—  
23 (A) by striking paragraph (1);  
24 (B) in paragraph (2), by striking “contract under  
25 this section which provides for the disbursement of  
26 funds, as described in subsection (a)(1)(B),” and in-  
27 serting “contract under section 1874A that provides for  
28 making payments under this part”;  
29 (C) in paragraph (3)(A), by striking “subsection  
30 (a)(1)(B)” and inserting “section 1874A(a)(3)(B)”;  
31 (D) in paragraph (4), by striking “carrier” and in-  
32 serting “medicare administrative contractor”;  
33 (E) in paragraph (5), by striking “contract under  
34 this section which provides for the disbursement of  
35 funds, as described in subsection (a)(1)(B), shall re-  
36 quire the carrier” and “carrier responses” and insert-  
37 ing “contract under section 1874A that provides for

1 making payments under this part shall require the  
2 medicare administrative contractor” and “contractor  
3 responses”, respectively; and

4 (F) by striking paragraph (6).

5 (5) Subsections (d), (e), and (f) are repealed.

6 (6) Subsection (g) is amended by striking “carrier or  
7 carriers” and inserting “medicare administrative contractor  
8 or contractors”.

9 (7) Subsection (h) is amended—

10 (A) in paragraph (2)—

11 (i) by striking “Each carrier having an agree-  
12 ment with the Secretary under subsection (a)” and  
13 inserting “The Secretary”; and

14 (ii) by striking “Each such carrier” and in-  
15 serting “The Secretary”;

16 (B) in paragraph (3)(A)—

17 (i) by striking “a carrier having an agreement  
18 with the Secretary under subsection (a)” and in-  
19 serting “medicare administrative contractor having  
20 a contract under section 1874A that provides for  
21 making payments under this part”; and

22 (ii) by striking “such carrier” and inserting  
23 “such contractor”;

24 (C) in paragraph (3)(B)—

25 (i) by striking “a carrier” and inserting “a  
26 medicare administrative contractor” each place it  
27 appears; and

28 (ii) by striking “the carrier” and inserting  
29 “the contractor” each place it appears; and

30 (D) in paragraphs (5)(A) and (5)(B)(iii), by strik-  
31 ing “carriers” and inserting “medicare administrative  
32 contractors” each place it appears.

33 (8) Subsection (l) is amended—

34 (A) in paragraph (1)(A)(iii), by striking “carrier”  
35 and inserting “medicare administrative contractor”;  
36 and

1 (B) in paragraph (2), by striking “carrier” and in-  
2 serting “medicare administrative contractor”.

3 (9) Subsection (p)(3)(A) is amended by striking “car-  
4 rier” and inserting “medicare administrative contractor”.

5 (10) Subsection (q)(1)(A) is amended by striking “car-  
6 rier”.

7 (d) EFFECTIVE DATE; TRANSITION RULE.—

8 (1) EFFECTIVE DATE.—

9 (A) APPLICATION TO COMPETITIVELY BID CON-  
10 TRACTS.—The amendments made by this section shall  
11 apply to contracts that are competitively bid on or after  
12 such date or dates (but not later than 2 years after the  
13 date of the enactment of this Act) as the Secretary  
14 specifies.

15 (B) CONSTRUCTION FOR CURRENT CONTRACTS.—  
16 Such amendments shall not apply to contracts in effect  
17 before the date specified under subparagraph (A) that  
18 continue to retain the terms and conditions in effect on  
19 such date until such date as the contract is let out for  
20 competitive bidding under such amendments.

21 (C) DEADLINE FOR COMPETITIVE BIDDING.—The  
22 Secretary shall provide for the letting by competitive  
23 bidding of all contracts for functions of medicare ad-  
24 ministrative contractors for annual contract periods  
25 that begin on or after October 1, 2008.

26 (2) GENERAL TRANSITION RULES.—The Secretary  
27 shall take such steps, consistent with paragraph (1)(B) and  
28 (1)(C), as are necessary to provide for an appropriate tran-  
29 sition from contracts under section 1816 and section 1842  
30 of the Social Security Act (42 U.S.C. 1395h, 1395u) to  
31 contracts under section 1874A, as added by subsection  
32 (a)(1).

33 (3) AUTHORIZING CONTINUATION OF MIP FUNCTIONS  
34 UNDER CURRENT CONTRACTS AND AGREEMENTS AND  
35 UNDER ROLLOVER CONTRACTS.—The provisions contained  
36 in the exception in section 1893(d)(2) of the Social Secu-  
37 rity Act (42 U.S.C. 1395ddd(d)(2)) shall continue to apply

1       notwithstanding the amendments made by this section, and  
2       any reference in such provisions to an agreement or con-  
3       tract shall be deemed to include a contract under section  
4       1874A of such Act, as inserted by subsection (a)(1), that  
5       continues the activities referred to in such provisions.

6       (e) REFERENCES.—On and after the effective date pro-  
7       vided under subsection (d)(1), any reference to a fiscal inter-  
8       mediary or carrier under title XI or XVIII of the Social Secu-  
9       rity Act (or any regulation, manual instruction, interpretative  
10      rule, statement of policy, or guideline issued to carry out such  
11      titles) shall be deemed a reference to an appropriate medicare  
12      administrative contractor (as provided under section 1874A of  
13      the Social Security Act).

14      (f) SECRETARIAL SUBMISSION OF LEGISLATIVE PRO-  
15      POSAL.—Not later than 6 months after the date of the enact-  
16      ment of this Act, the Secretary shall submit to the appropriate  
17      committees of Congress a legislative proposal providing for  
18      such technical and conforming amendments in the law as are  
19      required by the provisions of this section.

20      (g) REPORTS ON IMPLEMENTATION.—

21          (1) PROPOSAL FOR IMPLEMENTATION.—At least 1  
22      year before the date the Secretary proposes to first imple-  
23      ment the plan for implementation of the amendments made  
24      by this section, the Secretary shall submit a report to Con-  
25      gress and the Comptroller General of the United States  
26      that describes such plan. The Comptroller General shall  
27      conduct an evaluation of such plan and shall submit to  
28      Congress, not later than 6 months after the date the report  
29      is received, a report on such evaluation and shall include  
30      in such report such recommendations as the Comptroller  
31      General deems appropriate.

32          (2) STATUS OF IMPLEMENTATION.—The Secretary  
33      shall submit a report to Congress not later than October  
34      1, 2006, that describes the status of implementation of  
35      such amendments and that includes a description of the  
36      following:

1 (A) The number of contracts that have been com-  
2 petitively bid as of such date.

3 (B) The distribution of functions among contracts  
4 and contractors.

5 (C) A timeline for complete transition to full com-  
6 petition.

7 (D) A detailed description of how the Secretary  
8 has modified oversight and management of medicare  
9 contractors to adapt to full competition.

10 **SEC. 302. REQUIREMENTS FOR INFORMATION SECU-**  
11 **RITY.**

12 (a) IN GENERAL.—Section 1874A, as added by section  
13 301, is amended by adding at the end the following new sub-  
14 section:

15 “(e) REQUIREMENTS FOR INFORMATION SECURITY.—

16 “(1) DEVELOPMENT OF INFORMATION SECURITY PRO-  
17 GRAM.—A medicare administrative contractor that per-  
18 forms the functions referred to in subparagraphs (A) and  
19 (B) of subsection (a)(4) (relating to determining and mak-  
20 ing payments) shall develop and implement a contractor-  
21 wide information security program to provide information  
22 security for the operation and assets of the contractor with  
23 respect to such functions under this title. An information  
24 security program under this paragraph shall meet the re-  
25 quirements for information security programs imposed on  
26 Federal agencies under section 3534(b)(2) of title 44,  
27 United States Code (other than requirements under sub-  
28 paragraphs (B)(ii), (F)(iii), and (F)(iv) of such section).

29 “(2) INDEPENDENT AUDITS.—

30 “(A) PERFORMANCE OF ANNUAL EVALUATIONS.—  
31 Each year a medicare administrative contractor that  
32 performs the functions referred to in subparagraphs  
33 (A) and (B) of subsection (a)(4) (relating to deter-  
34 mining and making payments) shall undergo an evalua-  
35 tion of the information security program and practices  
36 of the contractor with respect to such functions under  
37 this title. The evaluation shall—

1 “(i) be performed by an independent entity  
2 that meets such requirements as the Inspector  
3 General of the Department of Health and Human  
4 Services may establish; and

5 “(ii) include testing of the effectiveness of in-  
6 formation security control techniques for an appro-  
7 priate subset of the contractor’s information sys-  
8 tems (as defined in section 3502(8) of title 44,  
9 United States Code) relating to such functions  
10 under this title and an assessment of compliance  
11 with the requirements of this subsection and re-  
12 lated information security policies, procedures,  
13 standards and guidelines.

14 “(B) DEADLINE FOR INITIAL EVALUATION.—

15 “(i) NEW CONTRACTORS.—In the case of a  
16 medicare administrative contractor covered by this  
17 subsection that has not previously performed the  
18 functions referred to in subparagraphs (A) and (B)  
19 of subsection (a)(4) (relating to determining and  
20 making payments) as a fiscal intermediary or car-  
21 rier under section 1816 or 1842, the first inde-  
22 pendent evaluation conducted pursuant subpara-  
23 graph (A) shall be completed prior to commencing  
24 such functions.

25 “(ii) OTHER CONTRACTORS.—In the case of a  
26 medicare administrative contractor covered by this  
27 subsection that is not described in clause (i), the  
28 first independent evaluation conducted pursuant  
29 subparagraph (A) shall be completed within 1 year  
30 after the date the contractor commences functions  
31 referred to in clause (i) under this section.

32 “(C) REPORTS ON EVALUATIONS.—

33 “(i) TO THE INSPECTOR GENERAL.—The re-  
34 sults of independent evaluations under subpara-  
35 graph (A) shall be submitted promptly to the In-  
36 spector General of the Department of Health and  
37 Human Services.

1 “(ii) TO CONGRESS.—The Inspector General  
2 of Department of Health and Human Services shall  
3 submit to Congress annual reports on the results of  
4 such evaluations.”.

5 (b) APPLICATION OF REQUIREMENTS TO FISCAL INTER-  
6 MEDIARIES AND CARRIERS.—

7 (1) IN GENERAL.—The provisions of section  
8 1874A(e)(2) of the Social Security Act (other than sub-  
9 paragraph (B)), as added by subsection (a), shall apply to  
10 each fiscal intermediary under section 1816 of the Social  
11 Security Act (42 U.S.C. 1395h) and each carrier under  
12 section 1842 of such Act (42 U.S.C. 1395u) in the same  
13 manner as they apply to medicare administrative contrac-  
14 tors under such provisions.

15 (2) DEADLINE FOR INITIAL EVALUATION.—In the case  
16 of such a fiscal intermediary or carrier with an agreement  
17 or contract under such respective section in effect as of the  
18 date of the enactment of this Act, the first evaluation  
19 under section 1874A(e)(2)(A) of the Social Security Act  
20 (as added by subsection (a)), pursuant to paragraph (1),  
21 shall be completed (and a report on the evaluation sub-  
22 mitted to the Secretary) by not later than 1 year after such  
23 date.

## 24 **TITLE IV—EDUCATION AND** 25 **OUTREACH IMPROVEMENTS**

### 26 **SEC. 401. PROVIDER EDUCATION AND TECHNICAL AS-** 27 **SISTANCE.**

28 (a) COORDINATION OF EDUCATION FUNDING.—

29 (1) IN GENERAL.—The Social Security Act is amended  
30 by inserting after section 1888 the following new section:

31 “PROVIDER EDUCATION AND TECHNICAL ASSISTANCE

32 “SEC. 1889. (a) COORDINATION OF EDUCATION FUND-  
33 ING.—The Secretary shall coordinate the educational activities  
34 provided through medicare contractors (as defined in sub-  
35 section (f), including under section 1893) in order to maximize  
36 the effectiveness of Federal education efforts for providers of  
37 services, physicians, practitioners, facilities, and suppliers.”.

1           (2) EFFECTIVE DATE.—The amendment made by  
2     paragraph (1) shall take effect on the date of the enact-  
3     ment of this Act.

4           (3) REPORT.—Not later than October 1, 2002, the  
5     Secretary shall submit to Congress a report that includes  
6     a description and evaluation of the steps taken to coordi-  
7     nate the funding of provider education under section  
8     1889(a) of the Social Security Act, as added by paragraph  
9     (1).

10          (b) INCENTIVES TO IMPROVE CONTRACTOR PERFORM-  
11     ANCE.—

12           (1) IN GENERAL.—Section 1874A, as added by section  
13     301(a)(1) and as amended by section 302, is amended by  
14     adding at the end the following new subsection:

15           “(f) INCENTIVES TO IMPROVE CONTRACTOR PERFORM-  
16     ANCE IN PROVIDER EDUCATION AND OUTREACH.—

17           “(1) METHODOLOGY TO MEASURE CONTRACTOR  
18     ERROR RATES.—In order to give medicare administrative  
19     contractors an incentive to implement effective education  
20     and outreach programs for providers of services, physicians,  
21     practitioners, facilities, and suppliers, the Secretary shall  
22     develop and implement by October 1, 2002, a methodology  
23     to measure the specific claims payment error rates of such  
24     contractors in the processing or reviewing of medicare  
25     claims.

26           “(2) GAO REVIEW OF METHODOLOGY.—Before imple-  
27     mentation of such methodology, the Comptroller General of  
28     the United States shall review, and make recommendations  
29     to the Secretary, regarding the adequacy of such method-  
30     ology.”.

31           (2) APPLICATION TO FISCAL INTERMEDIARIES AND  
32     CARRIERS.—The provisions of section 1874A(f)(1) of the  
33     Social Security Act, as added by paragraph (1), shall apply  
34     to each fiscal intermediary under section 1816 of the Social  
35     Security Act (42 U.S.C. 1395h) and each carrier under  
36     section 1842 of such Act (42 U.S.C. 1395u) in the same

1 manner as they apply to medicare administrative contrac-  
2 tors under such provisions.

3 (3) REPORT.—Before implementation of the method-  
4 ology developed under section 1874A(f)(1) of the Social Se-  
5 curity Act, as added by paragraph (1), the Secretary shall  
6 submit to Congress a report that describes how the Sec-  
7 retary intends to use the methodology in assessing medi-  
8 care contractor performance in implementing effective edu-  
9 cation and outreach programs, including whether to use  
10 such methodology as a basis for performance bonuses.

11 (c) REQUIREMENT TO MAINTAIN INTERNET SITES.—

12 (1) IN GENERAL.—Section 1889, as added by sub-  
13 section (a), is amended by adding at the end the following  
14 new subsection:

15 “(b) INTERNET SITES; FAQs.—The Secretary, and each  
16 medicare contractor insofar as it provides services (including  
17 claims processing) for providers of services, physicians, practi-  
18 tioners, facilities, or suppliers, shall maintain an Internet site  
19 which—

20 “(1) provides answers in an easily accessible format to  
21 frequently asked questions, and

22 “(2) includes all materials published by the Secretary  
23 or the contractor, respectively,  
24 relating to such providers of services, physicians, practitioners,  
25 facilities, and suppliers under the programs under this title and  
26 title XI insofar as it relates to such programs.”.

27 (2) EFFECTIVE DATE.—The amendment made by  
28 paragraph (1) shall take effect on October 1, 2002.

29 (d) IMPROVED PROVIDER EDUCATION AND TRAINING.—

30 (1) INCREASED FUNDING FOR ENHANCED EDUCATION  
31 AND TRAINING THROUGH MEDICARE INTEGRITY PRO-  
32 GRAM.—Section 1817(k)(4) (42 U.S.C. 1395i(k)(4)) is  
33 amended—

34 (A) in subparagraph (A), by striking “, subject to  
35 subparagraph (B)” and inserting “and functions de-  
36 scribed in subparagraph (C)(ii), subject to subpara-  
37 graphs (B) and (C)”;

1 (B) in subparagraph (B), by striking “The  
2 amount appropriated” and inserting “Subject to sub-  
3 paragraph (C), the amount appropriated”; and

4 (C) by adding at the end the following new sub-  
5 paragraph:

6 “(C) ENHANCED PROVIDER EDUCATION AND  
7 TRAINING.—

8 “(i) IN GENERAL.—In addition to the amount  
9 appropriated under subparagraph (B), the amount  
10 appropriated under subparagraph (A) for a fiscal  
11 year (beginning with fiscal year 2003) is increased  
12 by \$35,000,000.

13 “(ii) USE.—The funds made available under  
14 this subparagraph shall be used only to increase  
15 the conduct by medicare contractors of education  
16 and training of providers of services, physicians,  
17 practitioners, facilities, and suppliers regarding bill-  
18 ing, coding, and other appropriate items and may  
19 also be used to improve the accuracy, consistency,  
20 and timeliness of contractor responses to written  
21 and phone inquiries from providers of services, phy-  
22 sicians, practitioners, facilities, and suppliers.”.

23 (2) TAILORING EDUCATION AND TRAINING FOR SMALL  
24 PROVIDERS OR SUPPLIERS.—

25 (A) IN GENERAL.—Section 1889, as added by sub-  
26 section (a) and as amended by subsection (c), is further  
27 amended by adding at the end the following new sub-  
28 section:

29 “(c) TAILORING EDUCATION AND TRAINING ACTIVITIES  
30 FOR SMALL PROVIDERS OR SUPPLIERS.—

31 “(1) IN GENERAL.—Insofar as a medicare contractor  
32 conducts education and training activities, it shall take into  
33 consideration the special needs of small providers of serv-  
34 ices or suppliers (as defined in paragraph (2)). Such edu-  
35 cation and training activities for small providers or services  
36 and suppliers may include the provision of technical assist-  
37 ance (such as review of billing systems and internal con-

1       tols to determine program compliance and to suggest more  
2       efficient and effective means of achieving such compliance).

3       “(2) SMALL PROVIDER OF SERVICES OR SUPPLIER.—

4       In this subsection, the term ‘small provider of services or  
5       supplier’ means—

6               “(A) an institutional provider of services with  
7               fewer than 25 full-time-equivalent employees; or

8               “(B) a physician, practitioner, facility, or supplier  
9               with fewer than 10 full-time-equivalent employees.”.

10       (B) EFFECTIVE DATE.—The amendment made by  
11       subparagraph (A) shall take effect on October 1, 2002.

12       (e) ADDITIONAL PROVIDER EDUCATION PROVISIONS.—

13       (1) IN GENERAL.—Section 1889, as added by sub-  
14       section (a) and as amended by subsections (c) and (d)(2),  
15       is further amended by adding at the end the following new  
16       subsections:

17       “(d) ENCOURAGEMENT OF PARTICIPATION IN EDUCATION  
18       PROGRAM ACTIVITIES.—A medicare contractor may not use a  
19       record of attendance at (or failure to attend) educational activi-  
20       ties or other information gathered during an educational pro-  
21       gram conducted under this section or otherwise by the Sec-  
22       retary to select or track providers of services, physicians, prac-  
23       titioners, facilities, or suppliers for the purpose of conducting  
24       any type of audit or prepayment review.

25       “(e) CONSTRUCTION.—Nothing in this section or section  
26       1893(g) shall be construed as providing for disclosure by a  
27       medicare contractor of information that would compromise  
28       pending law enforcement activities or reveal findings of law en-  
29       forcement-related audits.

30       “(f) DEFINITIONS.—For purposes of this section and sec-  
31       tion 1817(k)(4)(C), the term ‘medicare contractor’ includes the  
32       following:

33       “(1) A medicare administrative contractor with a con-  
34       tract under section 1874A, a fiscal intermediary with a  
35       contract under section 1816, and a carrier with a contract  
36       under section 1842.

1           “(2) An eligible entity with a contract under section  
2           1893.

3       Such term does not include, with respect to activities of a spe-  
4       cific provider of services, physician, practitioner, facility, or  
5       supplier an entity that has no authority under this title or title  
6       XI with respect to such activities and such provider of services,  
7       physician, practitioner, facility, or supplier.”.

8           (2) EFFECTIVE DATE.—The amendment made by  
9       paragraph (1) shall take effect on the date of the enact-  
10      ment of this Act.

11       **SEC. 402. ACCESS TO AND PROMPT RESPONSES FROM**  
12       **MEDICARE ADMINISTRATIVE CONTRACTORS.**

13       (a) IN GENERAL.—Section 1874A, as added by section  
14       301 and as amended by sections 302 and 401(b)(1), is further  
15       amended by adding at the end the following new subsection:

16           “(g) COMMUNICATIONS WITH BENEFICIARIES, PROVIDERS  
17       OF SERVICES, PHYSICIANS, PRACTITIONERS, FACILITIES, AND  
18       SUPPLIERS.—

19           “(1) COMMUNICATION STRATEGY.—The Secretary  
20       shall develop a strategy for communications with bene-  
21       ficiaries and with providers of services, physicians, practi-  
22       tioners, facilities, and suppliers under this title.

23           “(2) RESPONSE TO WRITTEN INQUIRIES.—Each medi-  
24       care administrative contractor shall provide general written  
25       responses (which may be through electronic transmission)  
26       in a clear, concise, and accurate manner to inquiries by  
27       beneficiaries, providers of services, physicians, practitioners,  
28       facilities, and suppliers concerning the programs under this  
29       title within 45 business days of the date of receipt of such  
30       inquiries.

31           “(3) RESPONSE TO TOLL-FREE LINES.—Each medi-  
32       care administrative contractor shall maintain a toll-free  
33       telephone number at which beneficiaries, providers, physi-  
34       cians, practitioners, facilities, and suppliers may obtain in-  
35       formation regarding billing, coding, claims, coverage, and  
36       other appropriate information under this title.

37           “(4) MONITORING OF CONTRACTOR RESPONSES.—

1           “(A) IN GENERAL.—Each medicare administrative  
2 contractor shall, consistent with standards developed by  
3 the Secretary under subparagraph (B)—

4           “(i) maintain a system for identifying who  
5 provides the information referred to in paragraphs  
6 (2) and (3); and

7           “(ii) monitor the accuracy, consistency, and  
8 timeliness of the information so provided.

9           “(B) DEVELOPMENT OF STANDARDS.—

10          “(i) IN GENERAL.—The Secretary shall estab-  
11 lish (and publish in the Federal Register) stand-  
12 ards to monitor the accuracy, consistency, and  
13 timeliness of the information provided in response  
14 to written and telephone inquiries under this sub-  
15 section. Such standards shall be consistent with the  
16 performance requirements established under sub-  
17 section (b)(3).

18          “(ii) EVALUATION.—In conducting evaluations  
19 of individual medicare administrative contractors,  
20 the Secretary shall take into account the results of  
21 the monitoring conducted under subparagraph (A)  
22 taking into account as performance requirements  
23 the standards established under clause (i).

24          “(C) DIRECT MONITORING.—Nothing in this para-  
25 graph shall be construed as preventing the Secretary  
26 from directly monitoring the accuracy, consistency, and  
27 timeliness of the information so provided.”.

28          (b) EFFECTIVE DATE.—The amendment made by sub-  
29 section (a) shall take effect October 1, 2002.

30          (b) APPLICATION TO FISCAL INTERMEDIARIES AND CAR-  
31 RIERS.—The provisions of section 1874A(g) of the Social Secu-  
32 rity Act, as added by subsection (a), shall apply to each fiscal  
33 intermediary under section 1816 of the Social Security Act (42  
34 U.S.C. 1395h) and each carrier under section 1842 of such Act  
35 (42 U.S.C. 1395u) in the same manner as they apply to medi-  
36 care administrative contractors under such provisions.

1     **SEC. 403. RELIANCE ON GUIDANCE.**

2           (a) IN GENERAL.—Section 1871(e), as added by section  
3     102(a), is further amended by adding at the end the following  
4     new paragraph:

5           “(2) If—

6               “(A) a provider of services, physician, practitioner, fa-  
7               cility, or supplier follows written guidance (which may have  
8               been transmitted electronically) provided—

9                   “(i) by the Secretary; or

10                  “(ii) by a medicare contractor (as defined in sec-  
11                  tion 1889(f) and whether in the form of a written re-  
12                  sponse to a written inquiry under section 1874A(g)(1)  
13                  or otherwise) acting within the scope of the contractor’s  
14                  contract authority,

15           in response to a written inquiry with respect to the fur-  
16           nishing of an item or service or the submission of a claim  
17           for benefits for such an item or service;

18               “(B) the Secretary determines that—

19                   “(i) the provider of services, physician, practi-  
20                   tioner, facility, or supplier has accurately presented the  
21                   circumstances relating to such item, service, and claim  
22                   to the Secretary or the contractor in the written guid-  
23                   ance; and

24                   “(ii) there is no indication of fraud or abuse com-  
25                   mitted by the provider of services, physician, practi-  
26                   tioner, facility, or supplier against the program under  
27                   this title; and

28               “(C) the guidance was in error;

29     the provider of services, physician, practitioner, facility, or sup-  
30     plier shall not be subject to any penalty or interest (relating  
31     to an overpayment, if any) under this title (or the provisions  
32     of title XI insofar as they relate to this title) relating to the  
33     provision of such item or service or such claim if the provider  
34     of services, physician, practitioner, facility, or supplier reason-  
35     ably relied on such guidance. In applying this paragraph with  
36     respect to guidance in the form of general responses to fre-  
37     quently asked questions, the Secretary retains authority to de-

1     terminate the extent to which such general responses apply to the  
2     particular circumstances of individual claims. Nothing in this  
3     paragraph shall be construed as affecting the application of  
4     section 1870(c) (relating to no adjustment in the cases of cer-  
5     tain overpayments).”.

6           (b) EFFECTIVE DATE.—The amendment made by sub-  
7     section (a) shall apply to penalties imposed on or after the date  
8     of the enactment of this Act.

9     **SEC. 404. FACILITATION OF CONSISTENT INFORMATION**  
10     **TO PROVIDERS.**

11           The Secretary shall appoint an individual within the De-  
12     partment of Health and Human Services who shall be  
13     responsible—

14           (1) for responding to complaints and grievances from  
15     providers of services, physicians, practitioners, facilities,  
16     and suppliers under the medicare program under title  
17     XVIII of the Social Security Act (including provisions of  
18     title XI of the Social Security Act insofar as they relate to  
19     such title XVIII and are not administered by the Office of  
20     the Inspector General of the Department of Health and  
21     Human Services) concerning inconsistent information or in-  
22     consistent responses provided under such program; and

23           (2) in so responding, for facilitating an appropriate re-  
24     sponse from the Department of Health and Human Serv-  
25     ices or from appropriate medicare contractors.

26     Such individual shall not serve as an advocate for any specific  
27     policy within the Department.

28     **SEC. 405. POLICY DEVELOPMENT REGARDING EVALUA-**  
29     **TION AND MANAGEMENT (E & M) DOCU-**  
30     **MENTATION GUIDELINES.**

31           (a) IN GENERAL.—The Secretary may not implement any  
32     new documentation guidelines for evaluation and management  
33     physician services under the title XVIII of the Social Security  
34     Act on or after the date of the enactment of this Act unless  
35     the Secretary—

36           (1) has developed the guidelines in collaboration with  
37     practicing physicians (including both generalists and spe-

1 cialists) and provided for an assessment of the proposed  
2 guidelines by the physician community;

3 (2) has established a plan that contains specific goals,  
4 including a schedule, for improving the use of such guide-  
5 lines;

6 (3) has conducted appropriate and representative pilot  
7 projects under subsection (b) to test the evaluation and  
8 management documentation guidelines;

9 (4) finds that the objectives described in subsection (c)  
10 will be met in the implementation of such guidelines; and

11 (5) has established, and is implementing, a program to  
12 educate physicians on the use of such guidelines.

13 The Secretary may make changes to the manner in which exist-  
14 ing evaluation and management documentation guidelines are  
15 implemented to reduce paperwork burdens on physicians.

16 (b) PILOT PROJECTS TO TEST EVALUATION AND MAN-  
17 AGEMENT DOCUMENTATION GUIDELINES.—

18 (1) IN GENERAL.—The Secretary shall conduct under  
19 this subsection appropriate and representative pilot projects  
20 to test new evaluation and management documentation  
21 guidelines referred to in subsection (a).

22 (2) LENGTH AND CONSULTATION.—Each pilot project  
23 under this subsection shall—

24 (A) be voluntary;

25 (B) be of sufficient length as determined by the  
26 Secretary to allow for preparatory physician and medi-  
27 care contractor education, analysis, and use and assess-  
28 ment of potential evaluation and management guide-  
29 lines; and

30 (C) be conducted, in development and throughout  
31 the planning and operational stages of the project, in  
32 consultation with practicing physicians (including both  
33 generalists and specialists).

34 (3) RANGE OF PILOT PROJECTS.—Of the pilot projects  
35 conducted under this subsection—

36 (A) at least one shall focus on a peer review meth-  
37 od by physicians (not employed by a medicare con-

1 tractor) which evaluates medical record information for  
2 claims submitted by physicians identified as statistical  
3 outliers relative to definitions published in the Current  
4 Procedures Terminology (CPT) code book of the Amer-  
5 ican Medical Association;

6 (B) at least one shall focus on an alternative  
7 method to detailed guidelines based on physician docu-  
8 mentation of face to face encounter time with a patient;

9 (C) at least one shall be conducted for services  
10 furnished in a rural area and at least one for services  
11 furnished outside such an area; and

12 (D) at least one shall be conducted in a setting  
13 where physicians bill under physicians services in teach-  
14 ing settings and at least one shall be conducted in a  
15 setting other than a teaching setting.

16 (4) BANNING OF TARGETING OF PILOT PROJECT PAR-  
17 TICIPANTS.—Data collected under this subsection shall not  
18 be used as the basis for overpayment demands or post-pay-  
19 ment audits. Such limitation applies only to claims filed as  
20 part of the pilot project and lasts only for the duration of  
21 the pilot project and only as long as the provider is a par-  
22 ticipant in the pilot project.

23 (5) STUDY OF IMPACT.—Each pilot project shall ex-  
24 amine the effect of the new evaluation and management  
25 documentation guidelines on—

26 (A) different types of physician practices, includ-  
27 ing those with fewer than 10 full-time-equivalent em-  
28 ployees (including physicians); and

29 (B) the costs of physician compliance, including  
30 education, implementation, auditing, and monitoring.

31 (6) PERIODIC REPORTS.—The Secretary shall submit  
32 to Congress periodic reports on the pilot projects under this  
33 subsection.

34 (c) OBJECTIVES FOR EVALUATION AND MANAGEMENT  
35 GUIDELINES.—The objectives for new evaluation and manage-  
36 ment documentation guidelines developed by the Secretary shall  
37 be to—

1 (1) identify clinically relevant documentation needed to  
2 code accurately and assess coding levels accurately;

3 (2) decrease the level of non-clinically pertinent and  
4 burdensome documentation time and content in the physi-  
5 cian's medical record;

6 (3) increase accuracy by reviewers; and

7 (4) educate both physicians and reviewers.

8 (d) DEFINITIONS.—In this section—

9 (1) the term “rural area” has the meaning given that  
10 term in section 1886(d)(2)(D) of the Social Security Act,  
11 42 U.S.C. 1395ww(d)(2)(D); and

12 (2) the term “teaching settings” are those settings de-  
13 scribed in section 415.150 of title 42, Code of Federal Reg-  
14 ulations.

15 **SEC. 406. BENEFICIARY OUTREACH DEMONSTRATION**  
16 **PROGRAM.**

17 (a) IN GENERAL.—The Secretary shall establish a dem-  
18 onstration program (in this section referred to as the “dem-  
19 onstration program”) under which medicare specialists em-  
20 ployed by the Department of Health and Human Services pro-  
21 vide advice and assistance to medicare beneficiaries at the loca-  
22 tion of existing local offices of the Social Security Administra-  
23 tion.

24 (b) LOCATIONS.—

25 (1) IN GENERAL.—The demonstration program shall  
26 be conducted in at least 6 offices or areas. Subject to para-  
27 graph (2), in selecting such offices and areas, the Secretary  
28 shall provide preference for offices with a high volume of  
29 visits by medicare beneficiaries.

30 (2) ASSISTANCE FOR RURAL BENEFICIARIES.—The  
31 Secretary shall provide for the selection of at least 2 rural  
32 areas to participate in the demonstration program. In con-  
33 ducting the demonstration program in such rural areas, the  
34 Secretary shall provide for medicare specialists to travel  
35 among local offices in a rural area on a scheduled basis.

36 (c) DURATION.—The demonstration program shall be con-  
37 ducted over a 3-year period.

1 (d) EVALUATION AND REPORT.—

2 (1) EVALUATION.—The Secretary shall provide for an  
3 evaluation of the demonstration program. Such evaluation  
4 shall include an analysis of—

5 (A) utilization of, and beneficiary satisfaction  
6 with, the assistance provided under the program; and

7 (B) the cost-effectiveness of providing beneficiary  
8 assistance through out-stationing medicare specialists  
9 at local social security offices.

10 (2) REPORT.—The Secretary shall submit to Congress  
11 a report on such evaluation and shall include in such report  
12 recommendations regarding the feasibility of permanently  
13 out-stationing medicare specialists at local social security  
14 offices.

15 **SEC. 407. PROVIDER ENROLLMENT APPLICATIONS.**

16 (a) DEADLINES AND MONITORING.—Section 1866 (42  
17 U.S.C. 1395cc), as amended by section 205(a), is amended by  
18 adding at the end the following new subsection:

19 “(k) DEADLINES AND MONITORING OF ENROLLMENT AP-  
20 PPLICATIONS.—

21 “(1) DEADLINES.—The Secretary shall establish by  
22 regulation procedures under which there are deadlines for  
23 actions on applications for enrollment (and, if applicable,  
24 renewal of enrollment).

25 “(2) MONITORING.—The Secretary shall monitor the  
26 performance of medicare administrative contractors in  
27 meeting the deadlines established under paragraph (1).”.

28 (b) CONSULTATION BEFORE CHANGING PROVIDER EN-  
29 ROLLMENT FORMS.—Section 1871 (42 U.S.C. 1395hh), as  
30 amended by sections 101(a), 102, and 103, is further amended  
31 by adding at the end the following new subsection:

32 “(g) The Secretary shall consult with providers of services,  
33 physicians, practitioners, facilities, and suppliers before making  
34 changes in the provider enrollment forms required of such pro-  
35 viders, physicians, practitioners, facilities, and suppliers to be  
36 eligible to submit claims for which payment may be made under  
37 this title.”.

## **TITLE V—REVIEW, RECOVERY, AND ENFORCEMENT REFORM**

### **SEC. 501. PREPAYMENT REVIEW.**

(a) IN GENERAL.—Section 1874A, as added by section 301 and as amended by sections 302, 401(b)(1), and 402, is further amended by adding at the end the following new subsection:

“(h) CONDUCT OF PREPAYMENT REVIEW.—

“(1) STANDARDIZATION OF RANDOM PREPAYMENT REVIEW.—If a medicare administrative contractor conducts a random prepayment review, the contractor may only conduct such review in accordance with a standard protocol for random prepayment audits developed by the Secretary.

“(2) LIMITATIONS ON INITIATION OF NON-RANDOM PREPAYMENT REVIEW.—A medicare administrative contractor may not initiate non-random prepayment review of a provider of services, physician, practitioner, facility, or supplier based on the initial identification by that provider of services, physician, practitioner, facility, or supplier of an improper billing practice unless there is a likelihood of sustained or high level of payment error (as defined by the Secretary).

“(3) TERMINATION OF NON-RANDOM PREPAYMENT REVIEW.—The Secretary shall issue regulations relating to the termination, including termination dates, of non-random prepayment review. Such regulations may vary such a termination date based upon the differences in the circumstances triggering prepayment review.

“(4) CONSTRUCTION.—Nothing in this subsection shall be construed as preventing the denial of payments for claims actually reviewed under a random prepayment review. In the case of a provider of services, physician, practitioner, facility, or supplier with respect to which amounts were previously overpaid, nothing in this subsection shall be construed as limiting the ability of a medicare administrative contractor to request the periodic production of records

1 or supporting documentation for a limited sample of sub-  
2 mitted claims to ensure that the previous practice is not  
3 continuing.

4 “(5) RANDOM PREPAYMENT REVIEW DEFINED.—For  
5 purposes of this subsection, the term ‘random prepayment  
6 review’ means a demand for the production of records or  
7 documentation absent cause with respect to a claim.”.

8 (b) EFFECTIVE DATE.—

9 (1) IN GENERAL.—Except as provided in this sub-  
10 section, the amendment made by subsection (a) shall take  
11 effect on the date of the enactment of this Act.

12 (2) DEADLINE FOR PROMULGATION OF CERTAIN REG-  
13 ULATIONS.—The Secretary shall first issue regulations  
14 under section 1874A(h) of the Social Security Act, as  
15 added by subsection (a), by not later than 1 year after the  
16 date of the enactment of this Act.

17 (3) APPLICATION OF STANDARD PROTOCOLS FOR RAN-  
18 DOM PREPAYMENT REVIEW.—Section 1874A(h)(1) of the  
19 Social Security Act, as added by subsection (a), shall apply  
20 to random prepayment reviews conducted on or after such  
21 date (not later than 1 year after the date of the enactment  
22 of this Act) as the Secretary shall specify.

23 (c) APPLICATION TO FISCAL INTERMEDIARIES AND CAR-  
24 RIERS.—The provisions of section 1874A(h) of the Social Secu-  
25 rity Act, as added by subsection (a), shall apply to each fiscal  
26 intermediary under section 1816 of the Social Security Act (42  
27 U.S.C. 1395h) and each carrier under section 1842 of such Act  
28 (42 U.S.C. 1395u) in the same manner as they apply to medi-  
29 care administrative contractors under such provisions.

30 **SEC. 502. RECOVERY OF OVERPAYMENTS.**

31 (a) IN GENERAL.—Section 1874A, as added by section  
32 301 and as amended by sections 302, 401(b)(1), 402, and  
33 501(a), is further amended by adding at the end the following  
34 new subsection:

35 “(i) RECOVERY OF OVERPAYMENTS.—

36 “(1) USE OF REPAYMENT PLANS.—

1           “(A) IN GENERAL.—If the repayment, within the  
2           period otherwise permitted by a provider of services,  
3           physician, practitioner, facility, or supplier, of an over-  
4           payment under this title meets the standards developed  
5           under subparagraph (B), subject to subparagraph (C),  
6           and the provider, physician, practitioner, facility, or  
7           supplier requests the Secretary to enter into a repay-  
8           ment plan with respect to such overpayment, the Sec-  
9           retary shall enter into a plan with the provider, physi-  
10          cian, practitioner, facility, or supplier for the offset or  
11          repayment (at the election of the provider, physician,  
12          practitioner, facility, or supplier) of such overpayment  
13          over a period of at least one year, but not longer than  
14          3 years. Interest shall accrue on the balance through  
15          the period of repayment. The repayment plan shall  
16          meet terms and conditions determined to be appro-  
17          priate by the Secretary.

18           “(B) DEVELOPMENT OF STANDARDS.—The Sec-  
19          retary shall develop standards for the recovery of over-  
20          payments. Such standards shall—

21                   “(i) include a requirement that the Secretary  
22                   take into account (and weigh in favor of the use of  
23                   a repayment plan) the reliance (as described in sec-  
24                   tion 1871(e)(2)) by a provider of services, physi-  
25                   cian, practitioner, facility, and supplier on guidance  
26                   when determining whether a repayment plan should  
27                   be offered; and

28                   “(ii) provide for consideration of the financial  
29                   hardship imposed on a provider of services, physi-  
30                   cian, practitioner, facility, or supplier in consid-  
31                   ering such a repayment plan.

32          In developing standards with regard to financial hard-  
33          ship with respect to a provider of services, physician,  
34          practitioner, facility, or supplier, the Secretary shall  
35          take into account the amount of the proposed recovery  
36          as a proportion of payments made to that provider,  
37          physician, practitioner, facility, or supplier.

1                   “(C) EXCEPTIONS.—Subparagraph (A) shall not  
2                   apply if—

3                   “(i) the Secretary has reason to suspect that  
4                   the provider of services, physician, practitioner, fa-  
5                   cility, or supplier may file for bankruptcy or other-  
6                   wise cease to do business or discontinue participa-  
7                   tion in the program under this title; or

8                   “(ii) there is an indication of fraud or abuse  
9                   committed against the program.

10                  “(D) IMMEDIATE COLLECTION IF VIOLATION OF  
11                  REPAYMENT PLAN.—If a provider of services, physi-  
12                  cian, practitioner, facility, or supplier fails to make a  
13                  payment in accordance with a repayment plan under  
14                  this paragraph, the Secretary may immediately seek to  
15                  offset or otherwise recover the total balance out-  
16                  standing (including applicable interest) under the re-  
17                  payment plan.

18                  “(E) RELATION TO NO FAULT PROVISION.—Noth-  
19                  ing in this paragraph shall be construed as affecting  
20                  the application of section 1870(c) (relating to no ad-  
21                  justment in the cases of certain overpayments).

22                  “(2) LIMITATION ON RECOUPMENT.—

23                  “(A) NO RECOUPMENT UNTIL RECONSIDERATION  
24                  EXERCISED.—In the case of a provider of services, phy-  
25                  sician, practitioner, facility, or supplier that is deter-  
26                  mined to have received an overpayment under this title  
27                  and that seeks a reconsideration by a qualified inde-  
28                  pendent contractor on such determination under section  
29                  1869(b)(1), the Secretary may not take any action (or  
30                  authorize any other person, including any medicare  
31                  contractor, as defined in subparagraph (D)) to recoup  
32                  the overpayment until the date the decision on the re-  
33                  consideration has been rendered. If the provisions of  
34                  section 1869(b)(1) (providing for such a reconsider-  
35                  ation by a qualified independent contractor) are not in  
36                  effect, in applying the previous sentence any reference  
37                  to such a reconsideration shall be treated as a reference

1 to a redetermination by the fiscal intermediary or car-  
2 rier involved.

3 “(B) PAYMENT OF INTEREST.—

4 “(i) RETURN OF RECOUPED AMOUNT WITH IN-  
5 TEREST IN CASE OF REVERSAL.—Insofar as such  
6 determination on appeal against the provider of  
7 services, physician, practitioner, facility, or supplier  
8 is later reversed, the Secretary shall provide for re-  
9 payment of the amount recouped plus interest for  
10 the period in which the amount was recouped.

11 “(ii) INTEREST IN CASE OF AFFIRMATION.—  
12 Insofar as the determination on such appeal is  
13 against the provider of services, physician, practi-  
14 tioner, facility, or supplier, interest on the overpay-  
15 ment shall accrue on and after the date of the  
16 original notice of overpayment.

17 “(iii) RATE OF INTEREST.—The rate of inter-  
18 est under this subparagraph shall be the rate other-  
19 wise applicable under this title in the case of over-  
20 payments.

21 “(3) PAYMENT AUDITS.—

22 “(A) WRITTEN NOTICE FOR POST-PAYMENT AU-  
23 DITS.—Subject to subparagraph (C), if a medicare con-  
24 tractor decides to conduct a post-payment audit of a  
25 provider of services, physician, practitioner, facility, or  
26 supplier under this title, the contractor shall provide  
27 the provider of services, physician, practitioner, facility,  
28 or supplier with written notice (which may be in elec-  
29 tronic form) of the intent to conduct such an audit.

30 “(B) EXPLANATION OF FINDINGS FOR ALL AU-  
31 DITS.—Subject to subparagraph (C), if a medicare con-  
32 tractor audits a provider of services, physician, practi-  
33 tioner, facility, or supplier under this title, the con-  
34 tractor shall—

35 “(i) give the provider of services, physician,  
36 practitioner, facility, or supplier a full review and  
37 explanation of the findings of the audit in a man-

ner that is understandable to the provider of services, physician, practitioner, facility, or supplier and permits the development of an appropriate corrective action plan;

“(ii) inform the provider of services, physician, practitioner, facility, or supplier of the appeal rights under this title as well as consent settlement options (which are at the discretion of the Secretary);

“(iii) give the provider of services, physician, practitioner, facility, or supplier an opportunity to provide additional information to the contractor; and

“(iv) take into account information provided, on a timely basis, by the provider of services, physician, practitioner, facility, or supplier under clause (iii).

“(C) EXCEPTION.—Subparagraphs (A) and (B) shall not apply if the provision of notice or findings would compromise pending law enforcement activities, whether civil or criminal, or reveal findings of law enforcement-related audits.

“(D) MEDICARE CONTRACTOR DEFINED.—For purposes of this paragraph and paragraphs (4) and (5), the term ‘medicare contractor’ has the meaning given such term in section 1889(f).

“(4) NOTICE OF OVER-UTILIZATION OF CODES.—The Secretary shall establish, in consultation with organizations representing the classes of providers of services, physicians, practitioners, facilities, and suppliers, a process under which the Secretary provides for notice to classes of providers of services, physicians, practitioners, facilities, and suppliers served by a medicare contractor in cases in which the contractor has identified that particular billing codes may be overutilized by that class of providers of services, physicians, practitioners, facilities, or suppliers under the

1 programs under this title (or provisions of title XI insofar  
2 as they relate to such programs).

3 “(5) STANDARD METHODOLOGY FOR PROBE SAM-  
4 PLING.—The Secretary shall establish a standard method-  
5 ology for medicare contractors to use in selecting a sample  
6 of claims for review in the case of an abnormal billing pat-  
7 tern.

8 “(6) CONSENT SETTLEMENT REFORMS.—

9 “(A) IN GENERAL.—The Secretary may use a con-  
10 sent settlement (as defined in subparagraph (D)) to  
11 settle a projected overpayment.

12 “(B) OPPORTUNITY TO SUBMIT ADDITIONAL IN-  
13 FORMATION BEFORE CONSENT SETTLEMENT OFFER.—  
14 Before offering a provider of services, physician, practi-  
15 tioner, facility, or supplier a consent settlement, the  
16 Secretary shall—

17 “(i) communicate to the provider of services,  
18 physician, practitioner, facility, or supplier in a  
19 non-threatening manner that, based on a review of  
20 the medical records requested by the Secretary, a  
21 preliminary evaluation of those records indicates  
22 that there would be an overpayment; and

23 “(ii) provide for a 45-day period during which  
24 the provider of services, physician, practitioner, fa-  
25 cility, or supplier may furnish additional informa-  
26 tion concerning the medical records for the claims  
27 that had been reviewed.

28 “(C) CONSENT SETTLEMENT OFFER.—The Sec-  
29 retary shall review any additional information furnished  
30 by the provider of services, physician, practitioner, fa-  
31 cility, or supplier under subparagraph (B)(ii). Taking  
32 into consideration such information, the Secretary shall  
33 determine if there still appears to be an overpayment.  
34 If so, the Secretary—

35 “(i) shall provide notice of such determination  
36 to the provider of services, physician, practitioner,

1 facility, or supplier, including an explanation of the  
2 reason for such determination; and

3 “(ii) in order to resolve the overpayment, may  
4 offer the provider of services, physician, practi-  
5 tioner, facility, or supplier—

6 “(I) the opportunity for a statistically  
7 valid random sample; or

8 “(II) a consent settlement.

9 The opportunity provided under clause (ii)(I) does not  
10 waive any appeal rights with respect to the alleged  
11 overpayment involved.

12 “(D) CONSENT SETTLEMENT DEFINED.—For pur-  
13 poses of this paragraph, the term ‘consent settlement’  
14 means an agreement between the Secretary and a pro-  
15 vider of services, physician, practitioner, facility, or  
16 supplier whereby both parties agree to settle a pro-  
17 jected overpayment based on less than a statistically  
18 valid sample of claims and the provider of services,  
19 physician, practitioner, facility, or supplier agrees not  
20 to appeal the claims involved.”.

21 **SEC. 503. PROCESS FOR CORRECTION OF MINOR ER-**  
22 **RORS AND OMISSIONS ON CLAIMS WITHOUT**  
23 **PURSUING APPEALS PROCESS.**

24 The Secretary shall develop, in consultation with appro-  
25 priate medicare contractors (as defined in section 1889(f) of  
26 the Social Security Act, as added by section 401(e)(1)) and  
27 representatives of providers of services, physicians, practi-  
28 tioners, facilities, and suppliers, a process whereby, in the case  
29 of minor errors or omissions (as defined by the Secretary) that  
30 are detected in the submission of claims under the programs  
31 under title XVIII of such Act, a provider of services, physician,  
32 practitioner, facility, or supplier is given an opportunity to cor-  
33 rect such an error or omission without the need to initiate an  
34 appeal. Such process shall include the ability to resubmit cor-  
35 rected claims.

1   **SEC. 504. AUTHORITY TO WAIVE A PROGRAM EXCLU-**  
2                   **SION.**

3           The first sentence of section 1128(c)(3)(B) (42 U.S.C.  
4   1320a-7(c)(3)(B)) is amended to read as follows: “Subject to  
5   subparagraph (G), in the case of an exclusion under subsection  
6   (a), the minimum period of exclusion shall be not less than five  
7   years, except that, upon the request of the administrator of a  
8   Federal health care program (as defined in section 1128B(f))  
9   who determines that the exclusion would impose a hardship on  
10   beneficiaries under that program, the Secretary may waive the  
11   exclusion under subsection (a)(1), (a)(3), or (a)(4) with respect  
12   to that program in the case of an individual or entity that is  
13   the sole community physician or sole source of essential special-  
14   ized services in a community.”.

15   **SEC. 505. CLARIFICATION OF PRUDENT LAYPERSON**  
16                   **TEST FOR EMERGENCY SERVICES UNDER**  
17                   **THE MEDICARE FEE-FOR-SERVICE PRO-**  
18                   **GRAM.**

19           (a) IN GENERAL.—Section 1862 (42 U.S.C. 1395y) is  
20   amended by inserting after subsection (c) the following new  
21   subsection:

22           “(d) In the case of hospital services and physicians’ serv-  
23   ices that—

24           “(1) are furnished, to an individual who is not enrolled  
25   in a Medicare+Choice plan under part C, by a hospital or  
26   a critical access hospital; and

27           “(2) are needed to evaluate or stabilize an emergency  
28   medical condition (as defined in section 1852(d)(3)(B), re-  
29   lating to application of a prudent layperson rule) and that  
30   are provided to meet the requirements of section 1867,  
31   such services shall be deemed to be reasonable and necessary  
32   for the diagnosis or treatment of illness or injury for purposes  
33   of subsection (a)(1)(A).”.

34           (b) EFFECTIVE DATE.—The amendment made by sub-  
35   section (a) shall apply to items and services furnished on or  
36   after January 1, 2002.

## **TITLE VI—COVERAGE AND CODING IMPROVEMENTS**

### **SEC. 601. METHODS FOR DETERMINING PAYMENT BASIS FOR NEW LAB TEST.**

Section 1833(h) (42 U.S.C. 1395l(h)) is amended by adding at the end the following:

“(8)(A) The Secretary shall establish by regulation procedures for determining the basis for, and amount of, payment under this subsection for any clinical diagnostic laboratory test with respect to which a new or substantially revised HCPCS code is assigned on or after January 1, 2003 (in this paragraph referred to as ‘new tests’).

“(B) Determinations under subparagraph (A) shall be made only after the Secretary—

“(i) makes available to the public (through an Internet site and other appropriate mechanisms) a list that includes any such test for which establishment of a payment amount under this subsection is being considered for a year;

“(ii) on the same day such list is made available, causes to have published in the Federal Register notice of a meeting to receive comments and recommendations (and data on which recommendations are based) from the public on the appropriate basis under this subsection for establishing payment amounts for the tests on such list;

“(iii) not less than 30 days after publication of such notice convenes a meeting, that includes representatives of officials of the Centers for Medicare & Medicaid Services involved in determining payment amounts, to receive such comments and recommendations (and data on which the recommendations are based);

“(iv) taking into account the comments and recommendations (and accompanying data) received at such meeting, develops and makes available to the public (through an Internet site and other appropriate mechanisms) a list of proposed determinations with respect to the appropriate basis for establishing a payment amount under

1       this subsection for each such code, together with an expla-  
2       nation of the reasons for each such determination, the data  
3       on which the determinations are based, and a request for  
4       public written comments on the proposed determination;  
5       and

6           “(v) taking into account the comments received during  
7       the public comment period, develops and makes available to  
8       the public (through an Internet site and other appropriate  
9       mechanisms) a list of final determinations of the payment  
10      amounts for such tests under this subsection, together with  
11      the rationale for each such determination, the data on  
12      which the determinations are based, and responses to com-  
13      ments and suggestions received from the public.

14      “(C) Under the procedures established pursuant to sub-  
15      paragraph (A), the Secretary shall—

16           “(i) set forth the criteria for making determinations  
17      under subparagraph (A); and

18           “(ii) make available to the public the data (other than  
19      proprietary data) considered in making such determina-  
20      tions.

21      “(D) The Secretary may convene such further public meet-  
22      ings to receive public comments on payment amounts for new  
23      tests under this subsection as the Secretary deems appropriate.

24      “(E) For purposes of this paragraph:

25           “(i) The term ‘HCPCS’ refers to the Health Care Pro-  
26      cedure Coding System.

27           “(ii) A code shall be considered to be ‘substantially re-  
28      vised’ if there is a substantive change to the definition of  
29      the test or procedure to which the code applies (such as a  
30      new analyte or a new methodology for measuring an exist-  
31      ing analyte-specific test).”.